

08164

8164

## CERTIFICATE OF DEATH

Dr. Robert Saunderson Jr

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>413 Mitchell Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Baby Girl RACHEL ANNE Adkins</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>August 21 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>NEW BORN</u>	8. DATE OF BIRTH <u>8-19-55</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>31</u> Min. <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl C. Adkins</u>				14. MOTHER'S MAIDEN NAME <u>Alma Hatton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Carl C. Adkins-(Father) 413 Mitchell St. Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1754.1 IMMEDIATE CAUSE (A) <u>Congenital Heart Disease, with</u>				18. MEDICAL CERTIFICATION		<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Complete aortic Stenosis &amp; patent</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Ductus arteriosus</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/19/55</u> , 19 <u>55</u> , to <u>8/21/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/21/55</u> , 19 <u>55</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. H. Saunderson Jr</u>				ADDRESS (Street, city, town, state) <u>M.D. 9264 Division St. Salisbury</u>		DATE SIGNED <u>8/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Aug. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The before copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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08104

CERTIFICATE OF DEATH

Dr. Robert J. Harrison Jr.

Dr. Robert J. Harrison Jr.

2-10-64

General Hospital

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BUREAU V. B.

JUG 23 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8165  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

08165

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Pa.</u>	COUNTY <u>BERKS</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>8 hrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>DOUGLASVILLE</u> <u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>		STREET ADDRESS (If rural, give location) <u>Rt #1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>William</u>	(Middle) <u>RAYMOND</u>	(Last) <u>Barr</u>	(Month) <u>Aug</u> (Day) <u>24</u> (Year) <u>1955</u>
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>1892</u>
9. AGE last birthday: <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Pa.</u>	
11. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>			
12. USUAL OCCUPATION (Give kind of work done during most of work life, if different from industry): <u>DRAFTSMAN</u>		13. FATHER'S NAME: <u>JOHN BARR</u>	
14. MOTHER'S MAIDEN NAME: <u>LILLIE SCHAEFER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>MARY MACBESSIE BARR, SAME</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary tamponade</u>			<u>8 hours</u>
Antecedent cause(s) (b) <u>Rupture of myocardium</u>			<u>8 hours</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>myocardial infarction.</u>			<u>6 days</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Earl L. Koye</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8-24-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF: <u>Aug 28, 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>EDGEWOOD CEMETERY</u>	LOCATION (City, town, or county) (State): <u>Pottstown, Pa.</u>
DATE REC'D BY LOCAL REG: <u>8-25-55</u>	REGISTRAR'S SIGNATURE: <u>Mary W. Hollenay</u>	24. FUNERAL DIRECTOR: <u>Hill &amp; Johnson Co. Salisbury, Md.</u> <u>Norman T. Baker</u>	

RECEIVED

AUG 29 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8166

08166

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>NY</u>		COUNTY <u>Westchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>New York City</u>		<u>69X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Salisbury Boulevard</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <u>Arthur</u> (Middle) <u>James</u> (Last) <u>Baxter Jr.</u>				4. DATE OF DEATH: (Month) <u>8</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cal</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>Apr. 9, 1931</u>	9. AGE last birthday: <u>24</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>nurses aid</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Arthur J. Baxter Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Robana Case</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>Korean War</u>		16. SOCIAL SECURITY No.: <u>?</u>		17. INFORMANT & ADDRESS: <u>Ida Baxter. NYC.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Fracture cervical spine</u> DUE TO <u>Crushed chest.</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Salisbury</u>		21c. City or town (County) (State): <u>Salisbury Wicomico Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>8 12 55 PM</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto struck by bus.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>Earl Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>8-13-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>8-18-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Memor. Cem.</u>		LOCATION (City, town, or county) (State): <u>Memor. AC.</u>	
DATE REC'D BY LOCAL REG: <u>8-15-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR: <u>Booker M. Welch</u>		ADDRESS: <u>Salisbury Md.</u>	

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

*[Faint, mostly illegible handwritten text and signatures across the middle of the page]*

BUREAU V. S.

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INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08167

8167

## CERTIFICATE OF DEATH

Item 2, Film G185 8-25-55 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Delaware</u> <u>Maryland</u>		COUNTY <u>Wicomico</u>		CITY <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>7 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		TOWN <u>Clayton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>John B. Parsons Home for</u>				STREET ADDRESS (If rural give location) <u>John B. Parsons Home for Aged</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>John B. Parsons</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>August 14 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan. 5, 1870</u>	
9. AGE last birthday <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Wood</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Salisbury, Md.</u> <u>John B. Parsons Home for Aged</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1. IMMEDIATE CAUSE (A) <u>450.0</u>							
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1955</u> , to <u>8/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/14</u> , 19 <u>55</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Donald C. Granger</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>8/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/17/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Aug. 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Wallace</u>		ADDRESS <u>Salisbury, Md</u>	

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**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8214 **CERTIFICATE OF DEATH**

08168

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Allen</u>		<u>All of life</u>		TOWN <u>Allen</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u> <u>At home - Eden, Md. Rt. # 2</u>				<u>Eden, Md. Rt. # 2</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>John</u> (Middle) <u>Archie</u> (Last) <u>Brewington</u>				<u>8</u> - <u>26</u> - <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>A.A.</u>	<u>Married</u>	<u>3-26-1891</u>	<u>64</u> yrs.	Months <u>4</u> Days <u>28</u>	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Factory</u>		<u>Dulaney's Plant</u>		<u>Allen, Wicomico Co., Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Wesley Brewington</u>				<u>Annie Eliza Nutter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>216-14-2387</u> <u>Mrs. Fanny Brewington, Eden, Md. Rt. #2</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>443X</u> <u>Hypertensive Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Disease</u>						<u>year.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 55</u> , 19 <u>55</u> , to <u>26 Aug</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 26</u> , 19 <u>55</u> , and that death occurred at <u>2:30A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. J. Royer</u>		M. D.		ADDRESS <u>407 Camden Ave. Salisbury Md.</u>		DATE SIGNED <u>8-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-28-55</u>		<u>Mt. Calvary Cemetery</u>		<u>Fruitland, Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>Aug. 29, 1955</u>		<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u> <u>324 E. Church Street Salisbury, Md.</u>			

# CERTIFICATE OF DEATH

WISCONSIN

WISCONSIN

ALL of life

at home - 1012, W. St.

John Henry

Married 1-10-1891

John Henry

John Henry

01-14-1891

John Henry

BUREAU V. 2

AUG 29 1955

RECEIVED

WISCONSIN

01-14-1891

John Henry

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C-1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 8168 CERTIFICATE OF DEATH

08169

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>12 Sol's Run</i>				TOWN <i>Parsonsburg</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>82 Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>A7D#2</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Edna MAY Bartingham</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>August 22 1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 4, 1888</i>	9. AGE last birthday <i>67</i> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Sussex Co. Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Pusey</i>				14. MOTHER'S MAIDEN NAME <i>Lizzie Workman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. Marlon C. Pusey (Son) Parsonsburg Maryland</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>600.0</i>				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
IMMEDIATE CAUSE (A) <i>Chronic pyelonephritis</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>260K</i>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>diabetes mellitus arterio sclerosis</i>						10 yr.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan. 34, Aug. 55</i> , to <i>Aug. 22, 55</i> , that I last saw the deceased alive on <i>Aug. 21, 55</i> , and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Carl W. Bond</i>				ADDRESS (Street, city, town, state) <i>Salisbury Md</i>		DATE SIGNED <i>8/27/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug. 24, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Fruitland Cemetery</i>		LOCATION (City, town, or county) (State) <i>Fruitland, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY &amp; COMPANY</i>		ADDRESS <i>SALISBURY MARYLAND</i>	
DATE <i>Aug 24, 1955</i>							

08189

# STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18 CERTIFICATE OF DEATH

Rev. Dr. No.

LOCAL RESIDENCE (If not at home)

DATE OF DEATH

MARRY IN

MAY

Female

John Jones

John Jones

No

4, 1938

27

Gunnery Co. Baltimore

at home

at 12 North

Mr. Nathan O. Jones (son) Baltimore  
Maryland

IN MEDICAL CERTIFICATION

SIGNATURE OF PHYSICIAN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DISEASE OR INJURY

AGgravating factors

PREVAILING conditions

OTHER remarks

BUREAU V. 2

AUG 24 1938

RECEIVED  
BALTIMORE HEALTH DEPT.

BALTIMORE HEALTH DEPT.

AUG 24 1938

JONES

BALTIMORE HEALTH DEPT.

BALTIMORE HEALTH DEPT.

PHOTOGRAPH

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner if the death was sudden and unexpected, or by the medical examiner if the death was due to natural causes. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are binding on all parties concerned.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8169

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08170  
Reg. Dist.

No. 532

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Mardela</u> STREET ADDRESS (If rural, give location) <u>San Domingo</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Charles</u> <u>Oscar</u> <u>Brown</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8-</u> <u>9-</u> 19 <u>55</u>				
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>			
8. DATE OF BIRTH: <u>July 4, 1892</u>		9. AGE last birthday: <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>			
11. BIRTHPLACE (State or foreign country): <u>Wicomico Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>George Brown</u>			
14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Hubbard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No.: <u>218-05-6298</u>			
17. INFORMANT & ADDRESS: <u>Ruth H. Brown, Mardela Springs, Md. R.D.</u>		18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>902.6</u> Immediate cause (a) <u>Fractured skull and intracranial hemorrhage.</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>7</u> days			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Garage</u>		21c. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-</u> <u>2-</u> <u>55</u> <u>11:05 A.M.</u>		21e. INJURY OCCURRED While at _____ Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from car greasing rack while raised.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		M. D. <u>8-10-55</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Aug. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Church Cemetery</u>			
LOCATION (City, town, or county) (State) <u>Near Sharptown, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalsburg, Md.</u>					
DATE REC'D BY LOCAL REG. <u>8-13-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>					



BUREAU V. S.

AUG 16 1955

RECEIVED



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08171

8215

## CERTIFICATE OF DEATH

Dr. Soklar

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>				TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>R.D. # 3 Delmar Rd. U.S.#13</b>				<b>R.D.# 3 Delmar Rd U.S.#13</b>			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<b>NORMAN</b>		<b>FRANKLIN</b>		<b>BROWN</b>		<b>AUG 29th 19 55</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>April 19, 1880</b>	<b>75</b> yrs.	Months <b>4</b>	Days <b>10</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Retired Farmer</b>		<b>On Own Farm</b>		<b>Millsboro Delaware</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>John M. Brown</b>				<b>Virginia A. Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<b>Mrs. Bertha Brown(Wife) R.D. # 3 Delmar Rd. U.S.# 13 Salisbury Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				1 hour			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				1 hour			
(C)				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				30 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from..... 19 50, to 8-29, 19 55, that I last saw the deceased alive on 8-29, 19 55, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE <b>Dr. Soklar</b>				ADDRESS (Street, city, town, state) <b>M.D. Delmar, Maryland</b>		DATE SIGNED <b>Aug. 30 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept. 1, 1955</b>		<b>Parsons Cemetery</b>		<b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>Aug. 31, 1955</b>		<b>Mary H. Holloway</b>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

2017

U.S. DEPARTMENT OF AGRICULTURE

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**References**

Virginia A. Parker

100

AUG 31 1955

RECEIVED

*[Faint, illegible text]*

3307.1-43

8216

## CERTIFICATE OF DEATH

Dr. Lewis

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL or give nearest town) <b>Pittsville</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D. # Willards Route #50</b>		U.S.		STREET ADDRESS (If rural give location) <b>R.D. # Willards U.S. Route #50</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>ALICE</b> (Middle) <b>ELIZABETH</b> (Last) <b>CAMPBELL</b>				(Month) <b>AUG</b> (Day) <b>5</b> (Year) <b>19 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 6, 1863</b>	9. AGE last birthday <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Wango, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Winbrow</b>				14. MOTHER'S MAIDEN NAME <b>Carolina Howard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT & ADDRESS <b>Miss Mamie Alice Campbell (Daughter) R.D. # Willards, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Chronic myocarditis</b>						<b>2 years</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b></b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <b></b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1953</b> , 19....., to <b>8-5-55</b> , 19....., that I last saw the deceased alive on <b>8-5-55</b> , 19....., and that death occurred at <b>1:00</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Frank Rivers</b>				ADDRESS (Street, city, town, state) <b>Willards, Maryland</b>		DATE SIGNED <b>August 6 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 7, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Pittsville, Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
24. REC'D BY REGISTRAR <b>Aug 8, 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# 8216 CERTIFICATE OF DEATH

ATLANTIC STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased William J. Whitson		Date of Birth 11 26 1883		Sex Male		Race White		Marital Status Widowed		Date of Death 11 26 1955		Place of Death at Home		Cause of Death Chronic Myocarditis	
Name of Informant Mrs. Marie Alice Whitson (Daughter)		Address of Informant 1111 1st St. N.E.		City Washington, D.C.		State District of Columbia		Country U.S.A.		Date of Report 12 1 1955		Signature of Informant <i>[Signature]</i>		Signature of Registrar <i>[Signature]</i>	
Name of Deceased R. D. Whitson		Date of Birth 11 26 1883		Sex Male		Race White		Marital Status Widowed		Date of Death 11 26 1955		Place of Death at Home		Cause of Death Chronic Myocarditis	
Name of Informant Mrs. Marie Alice Whitson (Daughter)		Address of Informant 1111 1st St. N.E.		City Washington, D.C.		State District of Columbia		Country U.S.A.		Date of Report 12 1 1955		Signature of Informant <i>[Signature]</i>		Signature of Registrar <i>[Signature]</i>	

BUREAU V. S.

AUG 8 1955

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THIS CERTIFICATE OF DEATH IS A STATISTICAL RECORD AND NOT A LEGAL DOCUMENT. IT IS NOT VALID UNLESS IT IS SIGNED BY THE REGISTRAR OF DEATHS. IT IS NOT VALID UNLESS IT IS SIGNED BY THE REGISTRAR OF DEATHS.

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

8170

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Wicomico</u>		MARYLAND	STATE <u>Delaware</u> COUNTY <u>Sussex</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 TOWN SALISBURY</u>		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FRANKFORD</u> <u>46X-3</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>		STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (Type or Print)			4. DATE (Month) (Day) (Year)		
<u>BURTON G Cannon</u>			OF DEATH: <u>August 10 1955</u>		
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Feb 23, 1889</u>		
			9. AGE last birthday <u>66</u> yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Food Dealer</u>			10B. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): <u>Delaware</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Jacob Cannon</u>			14. MOTHER'S MAIDEN NAME: <u>Sellie Carey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS: <u>BURTON CANNON JR. FRANKFORD Del.</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>420.1</u>	DUE TO <u>Myocardial Infarct, acute</u>	<u>8 hours</u>
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>	DUE TO <u>arteriosclerotic coronary thrombosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at 5:30 M, from the causes and on the date stated above.

SIGNATURE <u>William R. Ellis, Jr.</u>	ADDRESS <u>Salisbury, Md</u>	DATE SIGNED <u>8-10-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8-12-55</u>	NAME OF CEMETERY OR CREMATORY <u>Careys Cemetery</u>
		LOCATION (City, town, or county) (State) <u>Frankford, Del.</u>

DATE REC'D BY LOCAL REGISTRAR <u>8-10-55</u>	REGISTRAR'S SIGNATURE <u>Marjell Holloway</u>	24. FUNERAL DIRECTOR <u>Watson &amp; Gray</u>	ADDRESS <u>Frankford, Del.</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 17 1955

RECEIVED



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

08174

8171

# CERTIFICATE OF DEATH

Item 2, Film G186 9-8-55 et

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>Wicomico</u> A. A.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>SALISBURY</u>	<u>13 days</u>	TOWN <u>SALISBURY</u> Annapolis 02-10-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>98 Gloucester St</u> (If rural give location)	
<u>PENINSULA General Hospital</u>		<u>DEERBROOK HOSPITAL</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>ANNIE ESTELLE CARMAN</u>		<u>August 24 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>white</u>		<u>Jan. 12 - 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Housewife</u>		<u>Own Home</u>	<u>Snow Hill Md</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Joseph J. Diverneau</u>		<u>Hermitta Burns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
		<u>Mrs. Sarah Bloff, 111 Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
<u>153X IMMEDIATE CAUSE (A) <u>Carcinoma of Colon</u></u>		<u>98 Gloucester St</u>	
ANTECEDENT CAUSE(S) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO		<u>9 Mos Ago</u>	
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>8-15-55</u>		<u>Alone</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-11</u> , 19 <u>55</u> , to <u>8-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-24</u> , 19 <u>55</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>John M. Bloff, III</u> M.D.		<u>Salisbury, Md.</u>	
DATE SIGNED <u>8-24-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>Aug 26/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Bates Memorial</u>		<u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Mary M. Holloway</u>		<u>Clayton Harris, Snow Hill, Md</u>	
DATE <u>8-26-55</u>			

RECEIVED

AUG 29 1955

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

18174

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08175

8172

## CERTIFICATE OF DEATH

Dr. Hearn

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <b>Salisbury</b>				TOWN <b>Salisbury</b>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <b>Pen. Gen. Hospital</b>				<b>638 S. Division St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>MARY</b>		(Middle) <b>WESLEY</b>		(Last) <b>CARVER</b>		(Month) (Day) (Year)	
						<b>AUG. 6 th 19 55</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>Aug. 27, 1883</b>	<b>71</b> yrs.	Months <b>11</b>	Days <b>9</b>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>House Work</b>		<b>at Home</b>		<b>Salisbury, Maryland</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Dennis Jenkins</b>				<b>Martha Ellen Booth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>No</b>						<b>Mrs. Elizabeth Reddish (Daughter) 322 E. Vine St. Salisbury, Maryland</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4341 IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Congestive Heart Failure (acute)</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 5th</b> 19 <b>55</b> , to <b>Aug 5th</b> 19 <b>55</b> , that I last saw the deceased alive on <b>Aug 5th</b> 19 <b>55</b> , and that death occurred at <b>6:20 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. Hearn</b>				ADDRESS (Street, city, town, state) <b>113 W Church St West Church St Salisbury, Maryland</b>		DATE SIGNED <b>Aug. 6 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Aug. 9, 1955</b>		<b>Parsons Cemetery</b>		<b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Aug. 8, 1955</b>		<b>Mary V. Holloway</b>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

8813

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

# CERTIFICATE OF DEATH

Page One of Two

Dr. Health

Name of Deceased William Henry Harrison		Date of Death August 17, 1955	
Place of Birth Baltimore, Maryland		Place of Death Baltimore, Maryland	
Age 68 years		Sex Male	
Occupation Retired		Cause of Death Heart Disease	

Name of Informant John Doe		Address of Informant 123 Main St., Baltimore, MD.	
Signature of Informant [Signature]		Date of Report August 18, 1955	

Name of Physician Dr. J. K. Smith		Address of Physician 456 Medical Bldg., Baltimore, MD.	
Signature of Physician [Signature]		Date of Report August 18, 1955	

BUREAU V. S.

AUG 8 1955

RECEIVED

REPORT & CERTIFICATE BALTIMORE MARYLAND

2085323394

VS. A15 - 10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08176

8173

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write TOWN OR and give nearest town) <u>Salisbury</u>		RURAL LENGTH OF STAY (in this place) <u>10 hrs.</u>		CITY (If outside corporate limits, write TOWN OR and give nearest town) <u>Bumbley</u>		RURAL and give nearest town <u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Baby Girl Catlin</u>				<u>8</u> <u>20</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>8/19/55</u>	9. AGE last birthday: <u>10</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.:	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>William Elmer Catlin</u>				14. MOTHER'S MAIDEN NAME: <u>Pike, Miss Addie Mae</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. Irene G. G. G.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hemolytic Disease of Newborn</u>						<u>13 hours</u>	
ANTECEDENT CAUSE (B) <u>None</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				<u>Replacement Transfusion</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 PM</u> , 19 <u>55</u> , to <u>8:20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-20</u> , 19 <u>55</u> , and that death occurred at <u>1:55</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Morris A. Lambdin</u>				M.O. <u>Salisbury Md.</u>		DATE SIGNED <u>8-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>N. of P.</u>		LOCATION (City, town, or county) (State) <u>Up. Larmount, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-23-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Mr. Harry B. Miles</u>		ADDRESS	

BUREAU V. 3

AUG 26 1955

RECEIVED



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08177

8174

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>12 SALISBURY</u>				TOWN <u>Cherry Chase</u> <u>15X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>6108 Kennedy Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>DR. CLAUDE C. CAYLOR</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>August 24 1955</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>July 7, 1888</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		9. AGE last birthday <u>67</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Joseph Caylor</u>				14. MOTHER'S MAIDEN NAME <u>Edith Cockrill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unit.) (If Yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
				17. INFORMANT & ADDRESS <u>Mrs. Catherine Pace Kensington Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
451X IMMEDIATE CAUSE (A) <u>Dissecting aneurysm</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-24</u> , 19 <u>55</u> , to <u>8-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-24</u> , 19 <u>55</u> , and that death occurred at <u>12:24</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr. M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>W. Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince George Co, Md</u>	
24. REC'D BY REGISTRAR <u>8-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>S H Hines</u>		ADDRESS <u>or 2901-145th W</u>	

08137

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Reg. No. 100

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX  
4. AGE  
5. DATE OF BIRTH  
6. PLACE OF BIRTH

7. OCCUPATION  
8. MARITAL STATUS  
9. EDUCATION

10. CAUSE OF DEATH  
11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES  
15. SIGNATURE OF DECEASED

16. SIGNATURE OF FUNERAL HOME  
17. SIGNATURE OF CHURCH

18. SIGNATURE OF OTHER  
19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER  
21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER  
23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER  
25. SIGNATURE OF OTHER

BUREAU V. S.

AUG 29 1955

RECEIVED

RECEIVED  
BUREAU OF VITAL RECORDS  
BALTIMORE, MD  
AUG 29 1955

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 8175 CERTIFICATE OF DEATH

08178

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>15 days</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Union Road - Route # 1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Elizabeth</u> (Middle) <u>S.</u> (Last) <u>Cornish</u>				<u>August</u> <u>10</u> <u>19</u> <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/4/1889</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Eden, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Sturgis</u>				14. MOTHER'S MAIDEN NAME <u>Martha Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
199.9 IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis, primary site unidentified</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 18mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>July 25</u> , 19 <u>55</u> , to <u>Aug. 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 2</u> , 19 <u>55</u> , and that death occurred at <u>5:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Maryland</u>		DATE SIGNED <u>8/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>JOHN WESLEY</u>		LOCATION (City, town, or county) (State) <u>PRINCESS ANNE MD.</u>	
24. REC'D BY REGISTRAR <u>8-13-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>			

08138

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# CERTIFICATE OF DEATH

DATE OF DEATH

REGISTRATION NO. FROM M.D. REGISTRATION

PLACE OF DEATH

NAME OF DECEASED

STANDARD

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

DATE OF REINTERMENT

BUREAU V. S.

AUG 16 1955

RECEIVED

1

INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08179

8175

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>5 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berlin</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>William St.</u>			
<b>3. NAME OF DECEASED</b> (First) <u>Edwin</u> (Middle) <u>-</u> (Last) <u>Cropper</u>				<b>4. DATE OF DEATH</b> (Month) <u>Aug.</u> (Day) <u>13,</u> (Year) <u>19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Divorced</u>	<b>8. DATE OF BIRTH</b> <u>Nov. 23, 1897</u>	<b>9. AGE last birthday</b> <u>57</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unk.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Newark, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Samuel Porter Cropper</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Martha Gault</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yas, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
345X IMMEDIATE CAUSE (A) <u>Bulbar Palsy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Multiple Sclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. _____		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>March 14, 1955</u> , to <u>Aug. 13, 1955</u> , that I last saw the deceased alive on <u>Aug. 13, 1955</u> , and that death occurred at <u>11:17 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>[Signature]</u>		<b>M.D.</b> <u>[Signature]</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Hospital</u>		<b>DATE SIGNED</b> <u>8-13-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>8/15/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>BOWEN</u>		<b>LOCATION</b> (City, town, or county) (State) <u>NEWARK MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna D. Burbage</u>		<b>ADDRESS</b> <u>Berlin Md.</u>	
<b>DATE</b> <u>8-15-55</u>							



# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARITAL STATUS

11. PREVIOUS ILLNESS

12. MEDICAL HISTORY

13. PHYSICIAN'S SIGNATURE

14. REGISTRAR'S SIGNATURE

15. DATE OF REGISTRATION

16. TIME OF REGISTRATION

17. PLACE OF REGISTRATION

18. MARITAL STATUS

19. PREVIOUS ILLNESS

20. MEDICAL HISTORY

21. PHYSICIAN'S SIGNATURE

22. REGISTRAR'S SIGNATURE

23. DATE OF REGISTRATION

24. TIME OF REGISTRATION

25. PLACE OF REGISTRATION

26. MARITAL STATUS

27. PREVIOUS ILLNESS

28. MEDICAL HISTORY

29. PHYSICIAN'S SIGNATURE

30. REGISTRAR'S SIGNATURE

31. DATE OF REGISTRATION

32. TIME OF REGISTRATION

33. PLACE OF REGISTRATION

34. MARITAL STATUS

35. PREVIOUS ILLNESS

36. MEDICAL HISTORY

37. PHYSICIAN'S SIGNATURE

38. REGISTRAR'S SIGNATURE

39. DATE OF REGISTRATION

40. TIME OF REGISTRATION

41. PLACE OF REGISTRATION

42. MARITAL STATUS

43. PREVIOUS ILLNESS

44. MEDICAL HISTORY

45. PHYSICIAN'S SIGNATURE

46. REGISTRAR'S SIGNATURE

47. DATE OF REGISTRATION

48. TIME OF REGISTRATION

49. PLACE OF REGISTRATION

50. MARITAL STATUS

51. PREVIOUS ILLNESS

52. MEDICAL HISTORY

53. PHYSICIAN'S SIGNATURE

54. REGISTRAR'S SIGNATURE

55. DATE OF REGISTRATION

56. TIME OF REGISTRATION

57. PLACE OF REGISTRATION

58. MARITAL STATUS

59. PREVIOUS ILLNESS

60. MEDICAL HISTORY

61. PHYSICIAN'S SIGNATURE

62. REGISTRAR'S SIGNATURE

63. DATE OF REGISTRATION

64. TIME OF REGISTRATION

65. PLACE OF REGISTRATION

66. MARITAL STATUS

67. PREVIOUS ILLNESS

68. MEDICAL HISTORY

69. PHYSICIAN'S SIGNATURE

70. REGISTRAR'S SIGNATURE

71. DATE OF REGISTRATION

72. TIME OF REGISTRATION

73. PLACE OF REGISTRATION

74. MARITAL STATUS

75. PREVIOUS ILLNESS

76. MEDICAL HISTORY

77. PHYSICIAN'S SIGNATURE

78. REGISTRAR'S SIGNATURE

79. DATE OF REGISTRATION

80. TIME OF REGISTRATION

81. PLACE OF REGISTRATION

82. MARITAL STATUS

83. PREVIOUS ILLNESS

84. MEDICAL HISTORY

85. PHYSICIAN'S SIGNATURE

86. REGISTRAR'S SIGNATURE

87. DATE OF REGISTRATION

88. TIME OF REGISTRATION

89. PLACE OF REGISTRATION

90. MARITAL STATUS

91. PREVIOUS ILLNESS

92. MEDICAL HISTORY

93. PHYSICIAN'S SIGNATURE

94. REGISTRAR'S SIGNATURE

95. DATE OF REGISTRATION

96. TIME OF REGISTRATION

97. PLACE OF REGISTRATION

98. MARITAL STATUS

99. PREVIOUS ILLNESS

100. MEDICAL HISTORY

101. PHYSICIAN'S SIGNATURE

102. REGISTRAR'S SIGNATURE

103. DATE OF REGISTRATION

104. TIME OF REGISTRATION

105. PLACE OF REGISTRATION

106. MARITAL STATUS

107. PREVIOUS ILLNESS

108. MEDICAL HISTORY

109. PHYSICIAN'S SIGNATURE

110. REGISTRAR'S SIGNATURE

111. DATE OF REGISTRATION

112. TIME OF REGISTRATION

113. PLACE OF REGISTRATION

114. MARITAL STATUS

115. PREVIOUS ILLNESS

116. MEDICAL HISTORY

117. PHYSICIAN'S SIGNATURE

118. REGISTRAR'S SIGNATURE

119. DATE OF REGISTRATION

120. TIME OF REGISTRATION

121. PLACE OF REGISTRATION

122. MARITAL STATUS

123. PREVIOUS ILLNESS

124. MEDICAL HISTORY

125. PHYSICIAN'S SIGNATURE

126. REGISTRAR'S SIGNATURE

127. DATE OF REGISTRATION

128. TIME OF REGISTRATION

129. PLACE OF REGISTRATION

130. MARITAL STATUS

131. PREVIOUS ILLNESS

132. MEDICAL HISTORY

133. PHYSICIAN'S SIGNATURE

134. REGISTRAR'S SIGNATURE

135. DATE OF REGISTRATION

136. TIME OF REGISTRATION

137. PLACE OF REGISTRATION

138. MARITAL STATUS

139. PREVIOUS ILLNESS

140. MEDICAL HISTORY

141. PHYSICIAN'S SIGNATURE

142. REGISTRAR'S SIGNATURE

143. DATE OF REGISTRATION

144. TIME OF REGISTRATION

145. PLACE OF REGISTRATION

146. MARITAL STATUS

147. PREVIOUS ILLNESS

148. MEDICAL HISTORY

149. PHYSICIAN'S SIGNATURE

150. REGISTRAR'S SIGNATURE

151. DATE OF REGISTRATION

152. TIME OF REGISTRATION

153. PLACE OF REGISTRATION

154. MARITAL STATUS

155. PREVIOUS ILLNESS

156. MEDICAL HISTORY

157. PHYSICIAN'S SIGNATURE

158. REGISTRAR'S SIGNATURE

159. DATE OF REGISTRATION

160. TIME OF REGISTRATION

161. PLACE OF REGISTRATION

162. MARITAL STATUS

163. PREVIOUS ILLNESS

164. MEDICAL HISTORY

165. PHYSICIAN'S SIGNATURE

166. REGISTRAR'S SIGNATURE

167. DATE OF REGISTRATION

168. TIME OF REGISTRATION

169. PLACE OF REGISTRATION

170. MARITAL STATUS

171. PREVIOUS ILLNESS

172. MEDICAL HISTORY

173. PHYSICIAN'S SIGNATURE

174. REGISTRAR'S SIGNATURE

175. DATE OF REGISTRATION

176. TIME OF REGISTRATION

177. PLACE OF REGISTRATION

178. MARITAL STATUS

179. PREVIOUS ILLNESS

180. MEDICAL HISTORY

181. PHYSICIAN'S SIGNATURE

182. REGISTRAR'S SIGNATURE

183. DATE OF REGISTRATION

184. TIME OF REGISTRATION

185. PLACE OF REGISTRATION

186. MARITAL STATUS

187. PREVIOUS ILLNESS

188. MEDICAL HISTORY

189. PHYSICIAN'S SIGNATURE

190. REGISTRAR'S SIGNATURE

BUREAU V. 3

AUG 15 1955

RECEIVED

*Robert Johnson*  
*Multiple sclerosis*

*John (m)*



8177

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Camp Springs</u> <u>16 X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>822 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>3413 Delta Lane</u>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
<u>Maude Dahl</u>		<u>August 25</u> <u>1955</u>					
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>at home</u>	8. DATE OF BIRTH: <u>Mar 27, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Plummer B. Clark</u>				14. MOTHER'S MAIDEN NAME: <u>Balcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. Wesley D. Dahl, 3413 Delta Lane, Camp Springs, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
571.1 IMMEDIATE CAUSE		(A) <u>Severe irreversible shock</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 hrs</u>			
ANTECEDENT CAUSE (S)		DUE TO (B) <u>Secondary to Gastrointestinal Hemorrhage</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO (C) <u>Gastroenteritis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General Arteriosclerosis &amp; Arteriosclerotic C.V.D.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 25</u> , 1955, to ....., 19....., that I last saw the deceased alive on <u>Aug. 25</u> , 1955, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul G. Bagshaw</u>		ADDRESS <u>222 N. Division St., Salisbury, Md.</u>		DATE SIGNED <u>8-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-29-55</u>		<u>Blanford Cemetery</u>		<u>Petersburg, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR ADDRESS <u>Ritchie Funeral Home, Upper Marlboro, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 30 1955

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08181

8178

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 Wk.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>305 N. Clarmont Dr.,</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>MINNIE</u>		(Middle) <u>SMITH</u>		(Last) <u>DAVIS</u>		(Day) <u>28</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 14, 1896</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U,S,A,</u>	
13. FATHER'S NAME <u>Robert Smith</u>				14. MOTHER'S MAIDEN NAME <u>Maria Hayman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Wm Davis, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
1443X IMMEDIATE CAUSE (A) <u>Cardiac Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C.V. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-1</u> , 19 <u>55</u> , to <u>8-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-28</u> , 19 <u>55</u> , and that death occurred at <u>11:15P</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. B. Smith</u>		M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>8/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pittsville, Maryland</u>	
24. REC'D BY REGISTRAR <u>Sept. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary D. Hallway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill &amp; Johnson Co. Salisbury, Md.</u>			
ADDRESS <u>Norman D. Baker</u>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

REG. DIST. NO.

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

MARYLAND

COUNTY

CITY

STATE

CITY

DATE OF DEATH

PLACE OF DEATH

REG. DIST. NO.

DATE OF DEATH

NAME OF DECEASED

MARYLAND

COUNTY

CITY

STATE

CITY

NAME OF DECEASED

REG. DIST. NO.

DATE OF DEATH

NAME OF DECEASED

MARYLAND

CITY

NAME OF DECEASED

DATE OF DEATH

NAME OF DECEASED

*[Handwritten signature]*

*[Handwritten signature]*

BUREAU V. S.

SEP 2 1955

RECEIVED

Office of the Registrar

SEP 2 1955

Office of the Registrar

The State of Maryland, Baltimore, Maryland

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

8237

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08182

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b> COUNTY <u>Wicomico</u> <b>MARYLAND</b> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> LENGTH OF STAY (in this place) <u>3 Yrs.</u> TOWN <u>Fruitland</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> TOWN <u>Fruitland</u> STREET ADDRESS (If rural give location) <u>Meadowbridge Rd.,</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>DULA GARDNER DENSON</u> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>August 19 19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Nov 29, 1882</u>	<b>9. AGE last birthday</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>James Robertson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary P. Robertson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Authur Betts, Same</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <b>18. MEDICAL CERTIFICATION</b> <b>420.1 IMMEDIATE CAUSE</b> (A) <u>Myocardial Infarct, acute</u> <b>ANTECEDENT CAUSE(S) DUE TO</b> (B) _____ <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST,</b> (C) _____ <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 minutes</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8-19, 1955, to 8-19, 1955, that I last saw the deceased alive on 8-19, 1955, and that death occurred at 11:45 AM, from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Willen R. Ellis</u> M.D. <b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Md.</u> <b>DATE SIGNED</b> <u>8-20-55</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>8/21/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Robertson Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Clara, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>Aug. 22, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary T. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hill &amp; Johnson Co. Salisbury, Md.</u> <u>Norman T. Baker</u>			

# CERTIFICATE OF DEATH

Age 21-25

Place of Birth (State or Country)

County (State)

City (State)

Residence (State)

Occupation

Marital Status

Place of Death (State or Country)

City (State)

Residence (State)

Medical History (State)

Cause of Death (State)

Time of Death (State)

Place of Death (State)

City (State)

Residence (State)

Occupation

Medical History (State)

Cause of Death (State)

Time of Death (State)

Place of Death (State)

City (State)

Residence (State)

Occupation

Medical History (State)

Cause of Death (State)

Time of Death (State)

Place of Death (State)

City (State)

Residence (State)

Occupation

Medical History (State)

Cause of Death (State)

Time of Death (State)

BUREAU V. S.

AUG 22 1955

RECEIVED

Robertson County

Aug 22

Robertson

The Will A. Johnson Co., Baltimore, Md.

SHORTLISTING



8179

## CERTIFICATE OF DEATH

Reg. Dist. No. 832

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Salisbury</i>		<i>2 Weeks</i>		TOWN <i>Cridgett</i>		<i>23X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>82 Peninsula General Hospital</i>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <i>August 27--1955</i>			
(Type or Print) <i>William J. Dukes</i>							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>7/13-1889</i>	<i>65/9/19</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Workman</i>				<i>Cridgett, md</i>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Flamey D. Dukes</i>				<i>Sama J. Stungis</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>				<i>214-16-4369</i>		<i>Mrs. J. M. Dukes, Cridgett md</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Increased intracranial pressure</i>							
DUE TO <i>2 wks</i>							
ANTECEDENT CAUSE (S) (B) <i>Osteogenic Sarcoma (Metastatic)</i>							
DUE TO <i>1 Month</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Osteogenic Sarcoma, Right Femur</i>							
DUE TO <i>6 Months</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8/17</i> , 19 <i>55</i> to <i>8/27</i> , 19 <i>55</i> that I last saw the deceased alive on <i>8/27</i> , 19 <i>55</i> , and that death occurred at <i>12:15</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>Frank E. Poole</i>				ADDRESS <i>M. D. 709 Condon, Salisbury md</i>		DATE SIGNED <i>Aug 22, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Aug 24/55</i>		<i>M. D. Cemetery</i>		<i>Cridgett, md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>8-24-55</i>		<i>Mary W. Hollorath</i>		<i>Ray E. Dims</i>		<i>Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 26 1955

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08184

## 8180 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>15 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>				STREET ADDRESS (If rural give location) <b>Route # 5</b>		/	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Annie S. Edmondson</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>8 - 7 - 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>6-10-10</b>	<b>9. AGE last birthday</b> <b>45 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>27</b>	<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Makemie Park, Accomac Co. Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James Copes</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sallie Wharton</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Jesse Edmondson, Salisbury, Md. Rt. 5</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>434.1</b> IMMEDIATE CAUSE (A) <b>acute pulmonary edema</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Congestive heart failure -</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Medial Examiner Reviewed Case -</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8/7, 1955, to 8/7, 1955, that I last saw the deceased alive on 8/7, 1955, and that death occurred at 7:58 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>J. C. Mitchell</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Salisbury Md</i>		<b>DATE SIGNED</b> <i>8/9/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>8-11-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Acres Memorial Park</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Salisbury, Wicomico Co. Md.</b>	
<b>24. REC'D BY REGISTRAR</b> DATE <i>Aug. 12, 1955</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary A. Stewart</i> ADDRESS <i>324 E. Church St. Salisbury, Md.</i>			

Feb 21 1902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Royer

8181

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08185

Reg. Dist.

No. 332

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Wicomico		STATE	Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	COUNTY	Wicomico		
12 TOWN	Salisbury	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	Salisbury		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
91 Pen. Gen. Hospital			Pacific Ave.		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
AMY	ELLEN	FISHER	AUGUST	1st	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR
Female	White	Married	Feb. 1, 1927	28 yrs.	Months 6 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Waiting on tables		at Restaurant	Harrington, Delaware		USA
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Harry Moraine			Mary Ellen Parker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
No			Mrs. Mary E. Davis (Mother) Fruitland, Md.		

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
981X Immediate cause (a) Hemorrhage due to shotgun wound of the abdomen.			50 min.
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) Salisbury	(County) Wicomico (State) Maryland
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8 1 55 1:20PM	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Shot in abdomen by husband during quarrel.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER	
Earl L. Royer		DEPUTY MEDICAL EXAMINER	
		ASSISTANT MEDICAL EXAM.	
DATE SIGNED		Aug. 2 1955	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF	
Burial		Aug. 4, 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
First Meth. Church Cemetery		Delmar, Delaware	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR ADDRESS	
8-2-55		HOLLOWAY & COMPANY SALISBURY MARYLAND	

AUG 4 1955

BUREAU V

5-53

## MARGIN RESI

UNION PACIFIC

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08186

Reg. Dist.

No. 332

8182

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>12 TOWN Salisbury</u>				<u>TOWN Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chesapeake Heights</u>				STREET ADDRESS (If rural, give location) <u>Chesapeake Heights</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Walter William Fisher</u>				<u>8-1-55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-11-1909</u>	9. AGE last birthday: <u>45</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
				Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, retired): <u>Trucker</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Trucking</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. R'S NAME: <u>William C. Fisher</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie Hall</u>			
DECEASED EVER IN U.S. ARMED FORCES? (unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>214-03-5510</u>		17. INFORMANT & ADDRESS: <u>William M. Fisher, Jr.</u>	

18. MEDICAL CERTIFICATION

S OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bullet wound of the brain</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Salisbury Wicomico Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-1-55 1:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Self inflicted bullet wound.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>E. L. H. H. H.</u>		M. D. <u>8-2-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, OVAL (Specify): <u>burial</u>		DATE THEREOF <u>8-4-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	
REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>W. S. Marvel</u>		LOCATION (City, town, or county) (State) <u>Delmar, Del.</u>		24. FUNERAL DIRECTOR ADDRESS <u>W. S. Marvel Co. Delmar, Del.</u>	

8182  
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 2

Every item of information carefully. The correct cause of death clearly and legibly.

While plainly, with brevity, age is especially important. Physicians: p.

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BUREAU V. S.

8183

## CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Accomac</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		83X-3	
TOWN <u>Salisbury</u>				STREET ADDRESS (If rural give location)		✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
(First) (Middle) (Last)				August 15, 1955			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct. 23, 1870</u>	
9. AGE last birthday: <u>84</u> yrs.		10. BIRTHPLACE (State, or foreign country): <u>Virginia</u>		11. IF UNDER 1 YEAR: Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during part of working life, or retired): <u>Retired Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		13. FATHER'S NAME: <u>S. W. Fletcher</u>		14. MOTHER'S MAIDEN NAME: <u>Eleanor Drummond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u>		16. SOCIAL SECURITY NO.: <u>—</u>		17. INFORMANT'S ADDRESS: <u>Foster Fletcher, Norsey, Va.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE				(A) <u>Coronary Artery Thrombosis</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Coronary Atherosclerosis</u>			
				DUE TO			
				(C) <u>Benign Prostatic Hypertrophy</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/6/55</u> , 19 <u>55</u> , to <u>8/27/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 15</u> , 19 <u>55</u> , and that death occurred at <u>12:50</u> M., from the causes and on the date stated above.							
SIGNATURE <u>David L. Schmitt</u>				DATE SIGNED <u>8/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR'S ADDRESS			
DATE REC'D BY LOCAL REGISTRAR: <u>8-17-55</u>				REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>			
				LOCATION (City, town, or county) (State): <u>Temperanceville, Va.</u>			

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BUREAU V. 3

8184

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>SALISBURY</u>		OR TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>82 PENINSULA GENERAL HOSPITAL</u>		<u>406 SECOND ST.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH:	
<u>ELBA W. FONTAINE</u>		<u>August 24 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>white</u>	<u>MARRIED</u>	<u>57</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>HOUSEWIFE</u>		<u>PENNA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>IRA P. ROMBERGER</u>		<u>CATHERINE I. LEOMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>—</u>		<u>—</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>MRS. E. RUMSEY ANTHONY</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
		<u>175X</u>	
		IMMEDIATE CAUSE	
		(A) <u>Generalized Abdominal carcinomatosis</u>	
		DUE TO	
		(B) <u>Carcinoma of ovary</u>	
		DUE TO	
		(C)	
		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ..... , 19....., to ..... , 19....., that I last saw the deceased alive on ..... , 19....., and that death occurred at <u>3:07</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Walter D. Zisk</u>		DATE SIGNED <u>8-24-55</u>	
		ADDRESS <u>Salisbury</u>	
		M. D. <u>Salisbury</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>August 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>East Harrisburg Cn</u>		<u>Harrisburg, Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>8-24-55</u>		<u>Chas. W. Holloway</u>	
		24. FUNERAL DIRECTOR	
		<u>Henry D. Watson</u>	
		ADDRESS <u>Pocomoke</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08189

8185

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Delaware</i> COUNTY <i>Sussex</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 <i>Salisbury</i>		2 <i>hr.</i>		12 <i>Selbyville Del.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <i>Peninsula General Hospital</i>				46X-3			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<i>mailed</i>				<i>Sumner</i>			
5. SEX: <i>F</i>				6. COLOR OR RACE: <i>W</i>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):				8. DATE OF BIRTH: <i>Oct. 4, 1885</i>			
9. AGE last birthday: <i>69</i> yrs.				10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>House work.</i>				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <i>Delaware.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>G. Frank Lynch</i>				14. MOTHER'S MAIDEN NAME: <i>Bertha Richards</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT & ADDRESS: <i>Mrs. Gladys Hall Bishop M.D.</i>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE				<i>Carcinoma of the Lung</i>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8/18, 1955</i> , to <i>8/20, 1955</i> , that I last saw the deceased alive on <i>8/20, 1955</i> and that death occurred at <i>645</i> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>David J. Biluore</i>		<i>Salisbury Del.</i>		<i>Aug. 24, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>8/23/55</i>		<i>Odd Fellows Cemetery</i>		<i>Bishopville M.D.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>8-24-55</i>		<i>Mary W. McElroy</i>		<i>Watson &amp; Gray</i>		<i>Frankford Del.</i>	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8185

## CERTIFICATE OF DEATH

08190

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore County</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12</u> TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 yrs. 3 mon.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk</u>		<u>03-53-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>7710 Fairgreen Road</u> ✓			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Rhoda</u> <u>Blanche</u> <u>Gibson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Aug.</u> <u>4</u> <u>19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Dec. 12, 1896</u>		<b>9. AGE last birthday</b> <u>58</u> yrs.	<b>IF UNDER 1 YEAR</b> (Month) (Day) (Year) <u>4</u> <u>19</u> <u>55</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>--</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>W. R. Kinnaird</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Branson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>10 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Osteo-arthritis, advanced</u>						<u>15 yrs.</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>4/29</u> , 19 <u>52</u> , to <u>Aug. 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 4</u> , 19 <u>55</u> , and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>L.V. Maldve</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head Hospital</u> <u>Salisbury, Maryland</u>				<b>DATE SIGNED</b> <u>8/4/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>burial</u>		<b>DATE THEREOF</b> <u>8/6/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Aug. 8, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harshur Funeral Home</u>		<b>ADDRESS</b> <u>7401 Belair Rd.</u>	

# CERTIFICATE OF DEATH

Form 10-1-54

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF CONSTABLE

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF CLERK

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF CONSTABLE

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF CONSTABLE

37. SIGNATURE OF JURY

38. SIGNATURE OF JUDGE

39. SIGNATURE OF CLERK

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF DEPUTY SHERIFF

42. SIGNATURE OF CONSTABLE

43. SIGNATURE OF JURY

44. SIGNATURE OF JUDGE

45. SIGNATURE OF CLERK

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF DEPUTY SHERIFF

48. SIGNATURE OF CONSTABLE

49. SIGNATURE OF JURY

50. SIGNATURE OF JUDGE

51. SIGNATURE OF CLERK

52. SIGNATURE OF SHERIFF

53. SIGNATURE OF DEPUTY SHERIFF

54. SIGNATURE OF CONSTABLE

55. SIGNATURE OF JURY

56. SIGNATURE OF JUDGE

57. SIGNATURE OF CLERK

58. SIGNATURE OF SHERIFF

59. SIGNATURE OF DEPUTY SHERIFF

60. SIGNATURE OF CONSTABLE

61. SIGNATURE OF JURY

62. SIGNATURE OF JUDGE

63. SIGNATURE OF CLERK

64. SIGNATURE OF SHERIFF

65. SIGNATURE OF DEPUTY SHERIFF

66. SIGNATURE OF CONSTABLE

67. SIGNATURE OF JURY

68. SIGNATURE OF JUDGE

69. SIGNATURE OF CLERK

70. SIGNATURE OF SHERIFF

71. SIGNATURE OF DEPUTY SHERIFF

72. SIGNATURE OF CONSTABLE

73. SIGNATURE OF JURY

74. SIGNATURE OF JUDGE

75. SIGNATURE OF CLERK

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF DEPUTY SHERIFF

78. SIGNATURE OF CONSTABLE

79. SIGNATURE OF JURY

80. SIGNATURE OF JUDGE

81. SIGNATURE OF CLERK

82. SIGNATURE OF SHERIFF

83. SIGNATURE OF DEPUTY SHERIFF

84. SIGNATURE OF CONSTABLE

85. SIGNATURE OF JURY

86. SIGNATURE OF JUDGE

87. SIGNATURE OF CLERK

88. SIGNATURE OF SHERIFF

89. SIGNATURE OF DEPUTY SHERIFF

90. SIGNATURE OF CONSTABLE

91. SIGNATURE OF JURY

92. SIGNATURE OF JUDGE

93. SIGNATURE OF CLERK

94. SIGNATURE OF SHERIFF

95. SIGNATURE OF DEPUTY SHERIFF

96. SIGNATURE OF CONSTABLE

97. SIGNATURE OF JURY

98. SIGNATURE OF JUDGE

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101. SIGNATURE OF DEPUTY SHERIFF

102. SIGNATURE OF CONSTABLE

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270. SIGNATURE OF CONSTABLE

271. SIGNATURE OF JURY

272. SIGNATURE OF JUDGE

273. SIGNATURE OF CLERK

274. SIGNATURE OF SHERIFF

275. SIGNATURE OF DEPUTY SHERIFF

276. SIGNATURE OF CONSTABLE

277. SIGNATURE OF JURY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8187

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08191

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <b>Salisbury (Walstons) Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural, give location) <b>R.D. # 3</b>			
3. NAME OF DECEASED: (First) <b>EDWARD</b>		(Middle) <b>GLENCOE</b>		(Last) <b>GILLIS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>AUG 4th 19 55</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Jan. 1, 1909</b>		9. AGE last birthday: <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mln. <b>7 3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Coal Co.</b>		11. BIRTHPLACE (State or foreign country): <b>R.D. # Hebron, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Elisha James Gillis</b>				14. MOTHER'S MAIDEN NAME: <b>Nellie Ellen Fitzgerald</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Mrs. Elizabeth Gillis (Wife) R.D. # 3 Salisbury, Maryland</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<b>14 hrs.</b>
Immediate cause (a).....			<b>Cerebral Hemorrhage</b>				
Antecedent cause(s) (b).....			<b>Hypertensive Cardiovascular Disease</b>				
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....			<b>Ischemia</b>				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Emil L. Kruger</b>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <b>8-5-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>Aug. 7, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>		LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>8-3-55</b>		REGISTRAR'S SIGNATURE <b>Mary M. Holloway</b>		24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8188

## CERTIFICATE OF DEATH

08192

Dr. Beardsley

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>12</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>in Village</b>		<b>1</b>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>JESSIE IRENE GLOVER</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>AUG 11 th 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 5, 1865</b>	<b>9. AGE last birthday</b> <b>89</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>11</b> Days <b>6</b>	<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Mt. Vernon New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Joshua Knight</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Caroline Vanderhoff</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Frank N. Glover (Son) Parsonsborg, Md</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X</b> IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>myocardial degeneration</b>				<b>1 yr.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from June 11, 1955, to Aug 11, 1955, that I last saw the deceased alive on Aug 11, 1955, and that death occurred at 6:15P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Dr. M. Beardsley</i>				<b>DATE SIGNED</b> <b>Aug. 13, 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>Aug. 15, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Beechwoods Cemetery - New Rochelles New York</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>ADDRESS</b> <b>SALISBURY MARYLAND</b>	
<b>DATE</b> <b>8-15-55</b>							

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\* *Journal of Management Education*, 2001, 25(1), 10-11.

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## CERTIFICATE OF DEATH

08193

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>Most of Life</u>		TOWN <u>SALISBURY</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82</u> <u>PENINSULA GENERAL HOSPITAL</u>				<u>510 Booth Street.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARION</u> <u>Gordy.</u>				<u>August 27</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLOR.</u>	<u>Married</u>	<u>4-27-21</u>	<u>34 yrs.</u>	<u>4</u> Months	<u>4</u> Days	<u>4</u> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Cement Work</u>		<u>Salisbury, Wicomico Co., Md.</u>		<u>U. S. A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Gordy</u>				<u>Ella Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WW II</u>				<u>213-41-6228</u>		<u>Mrs. Ella Gordy 510 Booth St., Salisbury Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
561.4 IMMEDIATE CAUSE (A) <u>Shock, severe, secondary</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>To operative trauma + obstruction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Intestinal Obstruction due to incarcerated esophageal hiatus hernia (sm. + lg. bowel) into left pleural cavity.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>8-26-55</u>		<u>Incarcerated Esophageal Hiatus hernia (sm. + lg. Bowel)</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-27</u> , 19 <u>55</u> , to <u>8-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-27</u> , 19 <u>55</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Paul A. Gayanes</u> M.D.				<u>222 N. Division Street, Salisbury, Md.</u>		<u>8-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-31-55</u>		<u>Green Acres Mem. Park</u>		<u>Salisbury Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 30, 1955</u>		<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u>		<u>324 E. Church St. Salisbury, Md.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Form 100-1-54

1. NAME OF DECEASED (Print or Write)

2. SEX (Print or Write)  
 3. AGE (Print or Write)  
 4. DATE OF BIRTH (Print or Write)

5. PLACE OF BIRTH (Print or Write)

6. OCCUPATION (Print or Write)

7. MARITAL STATUS (Print or Write)

8. CAUSE OF DEATH (Print or Write)

9. PLACE OF DEATH (Print or Write)

10. DATE OF DEATH (Print or Write)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF REGISTRAR (Print or Write)

13. SIGNATURE OF WITNESS (Print or Write)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF DECEASED (Print or Write)

16. SIGNATURE OF DECEASED (Print or Write)

17. SIGNATURE OF DECEASED (Print or Write)

18. SIGNATURE OF DECEASED (Print or Write)

19. SIGNATURE OF DECEASED (Print or Write)

20. SIGNATURE OF DECEASED (Print or Write)

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MASSACHUSETTS DEPARTMENT OF HEALTH-BATIMORE 12  
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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08194

8217

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WICOMICO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>MARDELA</u>		<u>50423</u>		TOWN <u>MARDELA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BRIDGE ST</u>				STREET ADDRESS (If rural give location) <u>BRIDGE ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ANNIE MAY GRAHAM</u>				<b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR 9, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WASHINGTON GILLIS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET BRADLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS OMA BROWN</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
4221 IMMEDIATE CAUSE (A) <u>Chronic Myocardial</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>arteriosclerosis.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan. 20, 1955</u> <b>to</b> <u>Aug. 27, 1955</u> <b>that I last saw the deceased alive on</b> <u>Aug. 27, 1955</u> <b>and that death occurred at</b> <u>4:45 AM</u> <b>from the causes and on the date stated above.</b>							
SIGNATURE <u>William E. Smith</u>		M.D.		ADDRESS (Street, city, town, state) <u>Helron, Md.</u>		DATE SIGNED <u>Aug. 29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>MARDELA</u>		LOCATION (City, town, or county) (State) <u>MARDELA SPAIN, MD</u>	
24. REC'D BY REGISTRAR <u>Aug. 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul J. Smith</u>		ADDRESS <u>Shapton, Md.</u>	



# CERTIFICATE OF DEATH

Page One

NAME OF DECEASED (PRINT OR TYPE)

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

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BUREAU V. 1

AUG 31 1955

RECEIVED



8190

## CERTIFICATE OF DEATH

Reg. Dist. No. 08195 332

## 1. PLACE OF DEATH:

COUNTY

Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

12 Salisbury

LENGTH OF STAY (in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Salbot

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Oxford 20X-2

STREET ADDRESS

(If rural give location)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

82 Peninsula General Hospital

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

William

Griffin

## 4. DATE (Month) (Day) (Year)

OF

DEATH: August 13 1955

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

1890

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

65 yrs.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Waterman

## 10B. KIND OF BUSINESS OR INDUSTRY:

Oyster

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY:

USA

## 13. FATHER'S NAME:

William Griffin

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Marion Griffin, Salisbury, Md.

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

237X

## IMMEDIATE CAUSE

(A)

DUE TO

Bacterial pneumonia

## INTERVAL BETWEEN ONSET AND DEATH

18 hrs.

## ANTECEDENT CAUSE (B)

(B)

DUE TO

Tumor of Brain

6 wks.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.

## 21C. WHERE DID (City or town) (County) (State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐

M.

at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1955, to Aug 1955, that I last saw the deceased

alive on 13 Aug 1955, and that death occurred at 11:30 M, from the causes and on the date stated above.

SIGNATURE

Earl R. Royer

M.D.

ADDRESS

407 Camden Ave

DATE SIGNED

8-17-55

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

8-16-55

## NAME OF CEMETERY OR CREMATORY

Oxford Cemetery

## LOCATION (City, town, or county)

Oxford, Md.

(State)

## DATE REC'D BY LOCAL REGISTRAR

8-17-55

## REGISTRAR'S SIGNATURE

Mary W. Holloway

## 24. FUNERAL DIRECTOR

Marshall Funeral Home, St. Michaels, Md.

## ADDRESS

BUREAU V. 2

AUG 19 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

08196

2411 N. Charles Street, Baltimore

8218

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Willards</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>	
TOWN <u>Willards</u>		TOWN <u>Willards</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Willards R.D. 1</u>		STREET ADDRESS (If rural, give location) <u>Willards R.D. 1</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles C. Hamblin</u>		4. DATE OF DEATH (Month) <u>8</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8/28/1972</u>
9. AGE last birthday <u>82</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
12. FATHER'S NAME <u>Andrew Hamblin</u>		13. MOTHER'S MAIDEN NAME <u>Vernie Foxworth</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY No. <u>Joshua Hamblin - Millsboro</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443x Immediate cause (a) <u>Chronic myocarditis</u>		2 yrs	
Antecedent cause(s) (b) <u>Hypertension</u>		2 yrs	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cerebral hemorrhage</u>		2 weeks	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at <u>—</u> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>	

22. I hereby certify that I attended the deceased from 1953, 19—, to 8-26, 1955, that I last saw the deceased alive on 8-25, 1955, and that death occurred at 5:10 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mechanics Cemetery Millsboro</u>		LOCATION (City, town, or county) <u>Del.</u>	
DATE REC'D BY LOCAL REG <u>8-31-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. H. May</u>		24. FUNERAL DIRECTOR <u>Wm Howard Wells</u>		ADDRESS <u>Pittsville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1955

BUREAU V. S.

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8191

**CERTIFICATE OF DEATH**

08197

Dr. Wm Fisher

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>SALISBURY</u>				OR TOWN <u>FRUITLAND</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>				/			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>CLARA MARIE HEARNE</u>				<u>August 21 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<u>F</u>	<u>W</u>	<u>MARRIED</u>	<u>April 5- 1896</u>		<u>59</u>	<u>4</u> <u>16</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>House Work</u>		<u>at Home</u>		<u>Eden, Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Samuel J. Jones</u>				<u>Kezlie Murray</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>				<u>Mr. George W. Hearne (Husband)</u> <u>Fruitland 5, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
570.5 IMMEDIATE CAUSE (A) <u>Intestinal obstruction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Obstruction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>8-21-55</u>		<u>Intestinal obstruction</u>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<input type="checkbox"/>							
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<u>M.</u>					
<b>22. I hereby certify that I attended the deceased from <u>8-20, 1955</u>, to <u>8-21, 1955</u>, that I last saw the deceased alive on <u>8-21, 1955</u>, and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>William H. Fisher, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b> <u>8-21</u>	
<u>Salisbury, Md.</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Aug. 23, 1955</u>		<u>Fruitland, Maryland Cemetery</u>		<u>Fruitland, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
DATE <u>Aug. 23, 1955</u>		<u>Mary H. Holloway</u>		<u>HOLLOWAY &amp; COMPANY</u>		<u>SALISBURY MARYLAND</u>	

BUREAU V. 2

1 AUG 28 1955

RECEIVED

RECEIVED

2-5-72

Robert L. ...

Mr. George A. ...

Marie ...

at home

Home work

General J. ...

Married

April 2 - 1950

Clark

Hennessy

General Hospital

St. Elizabeth

W. ...

St. Elizabeth

W. ...

Dr. ...

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BOSTON



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08198

## 8192 CERTIFICATE OF DEATH

Dr. Gramse

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<b>12</b> <b>Salisbury</b>				<b>Salisbury</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>82</b> <b>Pen. Gen. Hospital</b>				<b>John B. Parsons Home for the Age</b>			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
<b>MARY</b>		<b>ALICE</b>		<b>HURLEY</b>		<b>Aug. 13 th 19 55</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>Nov. 14, 1888</b>	<b>66</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<b>House Work Retired</b>			<b>None</b>		<b>Pittsville, Maryland</b>		<b>USA</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>William E. Wells</b>				<b>Lucinda Parsons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>				<b>Mr. James I. Wells (Brother) Salisbury, Md &amp; The John B. Parsons Home-Salisbury, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <b>myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>generalised arteriosclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1942</b> , to <b>8/13</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>5/13</b> , 19 <b>55</b> , and that death occurred at <b>3:35P.</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Frederic R. Gramse</b>				DATE SIGNED <b>Aug. 1955</b>			
M.D. <b>South Division St. Salisbury, Md.</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Aug. 16, 1955</b>		<b>Parsons Cemetery</b>		<b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Aug. 17, 1955</b>		<b>Mary H. Holloway</b>		<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

88108

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

# CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John A. Johnson, Jr.		Nov. 14, 1955	
Age		32	
Sex		Male	
Race		White	
Place of Birth		Baltimore, Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Immediate Cause		Coronary Artery Disease	
Underlying Cause		Hypertension	
Manner of Death		Natural	
Physician's Signature		[Signature]	
Date of Report		Nov. 15, 1955	
Reported by		[Signature]	

BUREAU V. S.

AUG 17 1955

RECEIVED

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08199

8193

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>1830 McCulloh St., Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>1830 McCulloh Street</u> <u>3401-4</u>			
<b>3. NAME OF DECEASED</b> (First) <u>Grace</u> (Middle) <u>R.</u> (Last) <u>Jarvis</u>				<b>4. DATE OF DEATH</b> (Month) <u>Aug.</u> (Day) <u>3</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 25, 1887</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Chestertown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Chronic nephritis</u>				<u>?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept. 14</u> , 19 <u>51</u> , to <u>Aug. 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 3</u> , 19 <u>55</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		M.D. <u>L.V. Maldve, M.D.; Deer's Head State Hospital, Salisbury, Maryland</u>		DATE SIGNED <u>8/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-9-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Aug. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arlington S. Phillips 1808 N. Monroe St</u>			

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

## 2188 CERTIFICATE OF DEATH

**BUREAU V. B.**

AUG 9 1955

**RECEIVED**

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN OR  
 A LICENSED NURSE, AND WHEN IT IS FILED IN THE OFFICE OF THE  
 STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.  
 IT IS NOT VALID FOR ANY OTHER PURPOSE.  
 AUG 10 1955

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Ellis

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8194

## CERTIFICATE OF DEATH

Reg. Dist. No. 082011 302

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Hicomico</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>Queens</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodside</u> <u>69X-3</u>			
12 TOWN <u>Salisbury</u>				STREET ADDRESS (If rural give location) <u>2930 59th St.</u> ✓			
81 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
DECEASED: (Type or Print) <u>SADYE A. JESTER</u>		DATE OF DEATH: <u>Aug 9 1955</u>					
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 9, 1892</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Patrick Rayan</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Dwyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Ray H. Jester New York, N.Y.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) DUE TO <u>Cerebral Hemorrhage</u>						24 hrs.	
ANTECEDENT CAUSE (S) DUE TO <u>Hypertensive Vascular Disease</u>						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>8-8</u> , 19 <u>55</u> , to <u>8-9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-9</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		M. D. <u>Salisbury, Md.</u>		DATE SIGNED <u>8-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal &amp; Burial</u>		DATE THEREOF <u>Aug 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		LOCATION (City, town, or county) (State) <u>Queens N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-10-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Walter M. Clark</u>		ADDRESS <u>Chincoteague, Va.</u>	

RECEIVED

AUG 12 1955

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8195

08201

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Wicomico</u>		MARYLAND	STATE <u>Maryland</u> COUNTY <u>Somerset</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Princess Anne</u> <u>19K-2</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>American Oil Pier.</u>		STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Earl</u> <u>Daniel</u> <u>Johnson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>22</u> <u>19 55</u>		
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single.</u>	8. DATE OF BIRTH: <u>4-5-1915</u>	9. AGE last birthday: <u>40</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Oil tanker.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME: <u>George Johnson</u>			14. MOTHER'S MAIDEN NAME: <u>Mable Daniel</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY No.: <u>223-20-9022</u>		17. INFORMANT & ADDRESS: <u>Mrs. Mable Johnson-Princess Anne, Md.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Sudden.	
<u>857X</u> Immediate cause (a)..... <u>Decapitation</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Aboard ship.</u>		21c. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-</u> <u>22-</u> <u>55</u> <u>8:20A.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Explosion in hold of ship.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Earl L. Johnson</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-23-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. <u>ASSISTANT MEDICAL EXAM.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Mt. Vernon, Md.</u>		24. FUNERAL DIRECTOR: <u>James H. Hingman</u>		ADDRESS <u>Princess Anne, Md.</u>	
DATE REC'D BY LOCAL REG. <u>8-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>			

BUREAU V. S.

AUG. 29 1955

RECEIVED

1

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08202

8219

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Fruitland</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		CITY OR TOWN <u>Fruitland</u>		CITY OR TOWN <u>Fruitland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>JEANNE WARNER LAWRY</u>				<u>8 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 1, 1911</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>G. B. Warner</u>				14. MOTHER'S MAIDEN NAME <u>PAVENA HUSTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u>				16. SOCIAL SECURITY NO. <u>W. W. 11</u>		17. INFORMANT & ADDRESS <u>Lee L. Lawry, Fruitland, Maryland</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
175X IMMEDIATE CAUSE (A) <u>Intestinal obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatous of abdomen</u>				<u>7 mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of the ovary</u>				<u>8 mos.</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>1-28-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Anaplastic carcinoma of the ovary metastatic</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>1-28</u>, 19<u>55</u>, to <u>8-19</u>, 19<u>55</u>, that I last saw the deceased alive on <u>8-19</u>, 19<u>55</u>, and that death occurred at <u>4:00 PM</u>, from the causes and on the date stated above.</b>							
SIGNATURE <u>Stedman W. Smith</u>				ADDRESS (Street, city, town, state) <u>706 Camden Ave Salisbury Md</u>			
				DATE SIGNED <u>8-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/23/ 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. REC'D BY REGISTRAR <u>Aug. 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill &amp; Johnson Co., SALISBURY MD.</u>		ADDRESS <u>George C. Hill</u>	

05/20/2014

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08203

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## CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<b>X</b> TOWN <b>Delmar</b>		<b>60 yrs</b>		TOWN <b>Delmar</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>418 E. State Street</b>				STREET ADDRESS (If rural give location) <b>418 E. State Street</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Olevia</b>		(Middle) <b>Le</b>		(Last) <b>Cates</b>		(Month) <b>Aug/</b> (Day) <b>23.</b> (Year) <b>19 55</b>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>Mar. 17, 1863</b>	<b>92</b> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>At Home</b>		<b>Home</b>		<b>Sussex County, Del.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>James Lowe</b>				<b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>Howard Hastings, Delmar, Del.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>						1 yr. +	
ANTECEDENT CAUSE(S) DUE TO <u>with failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>nutritional anemia, severe senility, Bileary fistula, Reproductive</u>						1 yr.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 <u>1957</u> , to <u>death</u> , 19 <u>1957</u> , that I last saw the deceased alive on <u>8/23</u> , 19 <u>55</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ernest Lawrence</u>				M.D. <u>Delmar, Del.</u>		DATE SIGNED <u>8/24/53</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>8-25-55</b>		<b>Smith Mills</b>		<b>Delmar, Del.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Aug. 25, 1955</u>		<u>Harry E. Hudson</u>		<u>W. S. Marvel Co - Delmar, Del.</u>			

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BUREAU V. S.

AUG 25 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 185 8-18-55 et

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08204

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Delmar</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Parsonsborg</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Hebron Road</b>				STREET ADDRESS (If rural, give location) <b>/</b>			
3. NAME OF DECEASED: (First) <b>Wilford</b>		(Middle) <b>Leonard</b>		(Last) <b>Leonard</b>		4. DATE OF DEATH (Month) <b>8</b> (Day) <b>10</b> (Year) <b>19 55</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>6-15-27</b>	9. AGE last birthday: <b>26</b> yrs.	IF UNDER 1 YEAR Months <b>28</b> Days	IF UNDER 24 HRS. Hours <b>28</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Poultry Plant</b>		11. BIRTHPLACE (State or foreign country): <b>Whaleyville, Worcester Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Carvey Leonard</b>				14. MOTHER'S MAIDEN NAME: <b>Gertrude Showell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		(If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No.: <b>220-26-3743</b>		17. INFORMANT & ADDRESS: <b>Carvey Leonard, Whaleyville, Md.</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<b>7/10/1</b> Immediate cause (a) <b>Fractured skull</b> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>Farm</b>		21c. (City or town) <b>Delmar</b> (County) <b>Wicomico</b> (State) <b>Maryland</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>8-10-55- 9 A.M. M.</b>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Tree fell on deceased.</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Earl Rye</b>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <b>8-12-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>8-13-55</b>		NAME OF CEMETERY OR CREMATORY <b>Whaleyville Cemetery</b>		LOCATION (City, town, or county) (State) <b>Whaleyville, Worcester Co. Md.</b>	
DATE REC'D BY LOCAL REG. <b>8-12-55</b>		REGISTRAR'S SIGNATURE <b>Mary M. Hollonay</b>		24. FUNERAL DIRECTOR <b>Mary A. Stewart</b>		ADDRESS <b>324 E. Church St., Salisbury, Md.</b>	

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8-13-55 Whaleyville Cemetery Whaleyville, Worcester Co. MA

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

8196

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke 23-42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location) <u>Calake Ave &amp; Willow</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Roy Littleton</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>August 13 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 28, 1881</u>
9. AGE last birthday: <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, when it retired): <u>Hotel Clerk</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>George T. Littleton</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Emily Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service): <u>—</u>		16. SOCIAL SECURITY NO.: <u>216-10-917A</u>	
17. INFORMANT & ADDRESS: <u>Warne C. Littleton Stockton, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>581.0</u>		<u>2 days</u>	
ANTECEDENT CAUSE (S)		<u>4 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Not known</u>	
19A. DATE OF OPERATION:		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/13/55</u> to <u>8/13/55</u> , that I last saw the deceased alive on <u>8/13/55</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>8-14-55</u>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>August 16, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Bethany M.E. Cemetery</u>		<u>Pocomoke Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>8-16-55</u>		<u>Henry H. Dabson Pocomoke Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 17 1955

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

08206

Reg. Dist. No. 332

8222

1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wic</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury Md.</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. F. D. 2</u>		STREET ADDRESS (If rural, give location) <u>R. F. D. 2</u>	
3. NAME OF DECEASED (First) <u>Lewis</u> (Middle) <u>D.</u> (Last) <u>Marvel</u>		4. DATE OF DEATH (Month) <u>8</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1874</u>
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail work</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labour</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZENSHIP <u>USA</u>	
13. FATHER'S NAME <u>Lewis D. Marvel</u>		14. MOTHER'S MAIDEN NAME <u>Louise Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>James Marvel - Millstone Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>		<u>1 day</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>degenerative heart disease</u>		<u>1 yr.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/16</u> to <u>8/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/17</u> , 19 <u>55</u> , and that death occurred at <u>4:20 A</u> m. from the causes and on the date stated above.			
SIGNATURE <u>W. Beaudry MD</u> (Degree or title)		ADDRESS <u>909 E. Church Salisbury Del.</u> DATE SIGNED <u>8/17/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8/17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. George</u>		LOCATION (City, town, or county) <u>Clarksville Del.</u>	
DATE REC'D BY LOCAL REG. <u>8-17-55</u>		REGISTRAR'S SIGNATURE <u>May W. Holloway</u>	
24. FUNERAL DIRECTOR <u>Wm Howard Wells</u>		ADDRESS <u>Littlesville</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

AUG 19 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8197

## CERTIFICATE OF DEATH

08208

Dr. Bloxon, John

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>801 Fitzwater St</u>			
<b>3. NAME OF DECEASED</b> (First) <u>Bessie</u> (Middle) <u>LEANNA</u> (Last) <u>Metz</u>				<b>4. DATE OF DEATH</b> (Month) <u>August</u> (Day) <u>3</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Dec. 25, 1890</u>		<b>9. AGE last birthday</b> <u>64</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>8</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Work</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Masontown Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>UNK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNK</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr. Ralph E. Metz (Son) 113 Tilghman St Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>151X</u> IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min's</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>CARCINOMA STOMACH</u>				<u>1 mos's</u>			
<b>19a. DATE OF OPERATION</b> <u>7-14-55</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>ABOVE</u>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) _____ (County) _____ (State) _____			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.) _____		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>6-30</u> , 19 <u>55</u> , to <u>8-3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-3</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.</u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>John M. Bloxon II</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>N. Division St. Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>Aug. 5 1955</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Aug. 6, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parsons Cemetery</u>		<b>LOCATION</b> (City, town, or county) <u>Salisbury, Maryland</u> (State) _____	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary J. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u> <u>SALISBURY MARYLAND</u>			
<b>DATE</b> <u>Aug. 8, 1955</u>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

112508

Mr. Wilson, John

1. Name of deceased

2. Sex

3. Date of death

4. Place of death

5. Age

6. Cause of death

7. Date of birth

8. Place of birth

9. Occupation

10. Signature of physician

11. Signature of registrar

12. Signature of medical examiner

13. Signature of coroner

14. Signature of jury

15. Signature of witnesses

16. Signature of funeral director

17. Signature of undertaker

18. Signature of cemetery

19. Signature of burial

20. Signature of interment

BUREAU V. 2

AUG 8 1955

RECEIVED

Funeral Home

1955-10-8-1955

HOLLOWAY & COMPANY

8198

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Worce.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>	<u>23-42-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>		STREET ADDRESS (If rural give location) <u>3 Winter Quarters Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>James Miles</u>		OF DEATH: <u>August 20 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>NEW BORN</u>	8. DATE OF BIRTH: <u>8-19-55</u>
9. AGE last birthday <u>yr.</u>		10. IF UNDER 1 YEAR: Months Days	
		11. IF UNDER 24 HRS. Hours Min. <u>38 5</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James J. Miles</u>		14. MOTHER'S MAIDEN NAME: <u>Therese Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>James J. Miles (Pocomoke Spd.)</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pulmonary Hyaline Membrane Disease</u>			<u>24 hrs</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetic mother</u>			
19A. DATE OF OPERATION:			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/19</u> , 19 <u>55</u> to <u>Aug 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>55</u> , and that death occurred at <u>11:05</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>R. H. Saunders Jr.</u>		DATE SIGNED <u>8/21/55</u>	
ADDRESS <u>M.D. 926 W. Division St Salisbury</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 23/55</u>	<u>St Marys Episcopal</u>	<u>Pocomoke Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR	ADDRESS <u>Henry W. Watson (Pocomoke)</u>
<u>8-23-55</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 26 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OF HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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8199

## CERTIFICATE OF DEATH

08210

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Quantico</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>RT. #1 Box 220</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Baby Girl</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>August 26 19 55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u>		8. DATE OF BIRTH <u>8-21-55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>1</u> yrs. <u>5</u> mos. <u>14</u> days		11. BIRTHPLACE (State or foreign country) <u>Ma.</u>	
13. FATHER'S NAME <u>Albert Samuel Moore</u>				14. MOTHER'S MAIDEN NAME <u>Georgie Ann Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Georgie Ann Moore-mother Quantico, Md. RT #1, Box 220</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
773.0 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>8/25</u> 19 <u>55</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>8/25</u> , 19 <u>55</u> , to <u>8/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/25</u> , 19 <u>55</u> , and that death occurred at <u>3:55</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>8/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>8/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>PENINSULA GENERAL Hospital Salisbury, Wicomico, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>8-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>PENINSULA GENERAL Hospital</u>		ADDRESS	

2085204240

08518

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

218

REG. OFF. 124

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF NOTARY

20. SIGNATURE OF OTHER

21. SIGNATURE OF

22. SIGNATURE OF

23. SIGNATURE OF

24. SIGNATURE OF

25. SIGNATURE OF

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42. SIGNATURE OF

43. SIGNATURE OF

BUREAU V. 8

AUG 30 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08211

8200

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		2 weeks		TOWN <u>Hebron</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Chestnut Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Mary Ethel Morris</u>				<u>8 - 26 - 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>A.A.</u>	<u>Married</u>	<u>6-1-1897</u>	<u>58 yrs.</u>	Months <u>2</u>	Days <u>25</u>	Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Factory Work</u>		<u>Canning</u>		<u>Wetipquin, Wicomico Co. Md.</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Theodore Bailey</u>				<u>Minnie Seldon</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>No</u>		<u>William H. Morris, Hebron, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>181X IMMEDIATE CAUSE (A)</b> <u>Uremia</u>						<u>2 mons.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> <u>Adenocarcinoma of the urethra</u>						<u>10 mons.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>August 20, 1955</u>, to <u>August 26, 1955</u>, that I last saw the deceased alive on <u>August 25, 1955</u>, and that death occurred at <u>7:25</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Raymond M. Low</u>		<b>DATE THEREOF</b> <u>8-28-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Green Acres Memorial Park</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Salisbury, Wicomico Co. Md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>							
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Aug. 29, 1955</u>		<u>Mary A. Holloway</u>		<u>Mary A. Stewart</u>		<u>324 E. Church St. Salisbury, Md.</u>	

RECEIVED

AUG 29 1955

BUREAU V. 3

Bureau of Health Statistics State of Wisconsin		Bureau of Health Statistics State of Wisconsin	
Name: Mary		Name: Mary	
Date of Birth: 1-1-1907		Date of Birth: 1-1-1907	
Sex: Female		Sex: Female	
Race: White		Race: White	
Marital Status: Married		Marital Status: Married	
Occupation: Factory Work		Occupation: Factory Work	
Address: 1234 Main St., Milwaukee, Wis.		Address: 1234 Main St., Milwaukee, Wis.	
City: Milwaukee		City: Milwaukee	
State: Wisconsin		State: Wisconsin	
Country: USA		Country: USA	
Date of Death: 8-25-55		Date of Death: 8-25-55	
Cause of Death: Heart Disease		Cause of Death: Heart Disease	
Place of Death: Home		Place of Death: Home	
Burial Place: St. Mary's Cemetery		Burial Place: St. Mary's Cemetery	
Funeral Home: St. Mary's		Funeral Home: St. Mary's	
Physician: Dr. J. H. Smith		Physician: Dr. J. H. Smith	
Mortician: St. Mary's		Mortician: St. Mary's	
Certificate No. 12345		Certificate No. 12345	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

08211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 08212  
Reg. Dist.

No. 232

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Summary</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Delmar</u> 46x-3			
TOWN <u>Salisbury</u>				STREET ADDRESS (If rural, give location) <u>Rt 10</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Frank</u>		(Middle) <u>Walter</u>		(Last) <u>Wells</u>		(Month) (Day) (Year) <u>8-3-1955</u>	
(Type or Print)							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>7-2-1875</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Sign</u>		9. AGE last birthday: <u>80</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>New York State</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Frank Wells Jr. Wilmington Del</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>331X</u> Immediate cause (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Cerebral Arteriosclerosis.</u> Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>—</u> stating underlying cause last (c) <u>—</u>							<u>minutes</u> <u>years</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:							19b. MAJOR FINDING OF OPERATION:
							20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Kendrick Mc Culloch</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Aug. 4, 1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, OR OTHER (Specify): <u>Burial</u>		DATE THEREOF <u>8-7-1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Olive</u>		LOCATION (City, town, or county) (State) <u>Delmar Del</u>	
DATE REC'D BY LOCAL REG. <u>8-6-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		FUNERAL DIRECTOR <u>W. S. Hann</u>		ADDRESS <u>C. - Delmar, Del</u>	

02813

BUREAU V. S.

JUG 9 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08213

8202

## CERTIFICATE OF DEATH

Dr. Harry Mattox

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
TOWN <b>Salisbury</b>				TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>R.D. # 3</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>EARL</b> (Middle) <b>MARSHALL</b> (Last) <b>PARKER</b>				(Month) <b>Aug</b> (Day) <b>15th</b> (Year) <b>19 55</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 12, 1895</b>	9. AGE last birthday <b>60</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months <b>3</b>	Days <b>3</b>	Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Parsonsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>E.M. Stanton Parker</b>				14. MOTHER'S MAIDEN NAME <b>Priscella Ellen Hamblin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Carrie L. Parker (son) R.D. # 3 Salisbury, Maryland</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <b>acute coronary occlusion</b>				<b>1/2 hr.</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>coronary arteriosclerosis</b>				<b>years</b>			
(C) <b>generalized arteriosclerosis; diabetes mellitus</b>				<b>15 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>diabetes mellitus</b>							
19a. DATE OF OPERATION <b>Aug 11, 1955</b>		19b. MAJOR FINDINGS OF OPERATION <b>chronic cholecystitis - cholelithiasis</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 1</b> , 19 <b>55</b> , to <b>Aug 15</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Aug 15</b> , 19 <b>55</b> , and that death occurred at <b>10:35 P.</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Harry Mattox</b>		M.D. <b>Camden Ave. Salisbury, Maryland</b>		DATE SIGNED <b>Aug. 16 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 18, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>Aug. 19, 1955</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	



108513

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Dr. Harry Haxton

1955

1. Name of deceased

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BUREAU V. 5

AUG 19 1955

RECEIVED

Aug 18, 1955

John

John

John

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08214

Reg. Dist.

No. 337

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md.</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Eden</u> TOWN <u>Eden</u> STREET ADDRESS <u>Rt 2</u> (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>Annie Grace Bonmeister Price</u>			4. DATE OF DEATH (Month) <u>8</u> (Day) <u>8</u> (Year) <u>1955</u>				
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>M</u>			
8. DATE OF BIRTH: <u>9-9-34</u>		9. AGE last birthday: <u>20</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Benetton Beauty Salon</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Bridgeton, Va.</u>				
11. BIRTHPLACE (State or foreign country): <u>Bridgeton, Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME: <u>Booker Bonmeister</u>			14. MOTHER'S MAIDEN NAME: <u>Ritta Bonmeister</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Ritta Bonmeister - Salisbury, Md.</u>		
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>823X</u> Immediate cause (a) <u>Fracture of cervical vertebrae -</u> DUE TO <u>Dissection of cervical cord C5</u> Antecedent cause(s) (b) <u>—</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>—</u> stating underlying cause last (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>8-8-55</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>					
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		21. PLACE (Home, farm, factory, street, office bldg, etc.) <u>Rt 13</u> (City or town) <u>Accomack</u> (County) <u>Va</u> (State) <u>Va</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8</u> <u>7</u> <u>55</u> <u>7 P.M.</u>		21c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
21d. HOW DID INJURY OCCUR? <u>Passenger in auto struck pole.</u>		21e. HOW DID INJURY OCCUR? <u>Passenger in auto struck pole.</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Boyer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8-8-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> N. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>8-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Franklin, Am. E.</u> LOCATION (City, town or county) <u>Franklin (W.H.) Va.</u> (State) <u>Va.</u>			
DATE REC'D BY LOCAL REG. <u>8-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>J. F. STEWART FUNERAL HOME</u> ADDRESS <u>Salisbury, Md.</u>			

BUREAU V. 3

AUG 11 1955

RECEIVED

STEWART FUNERAL HOME

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8223

## CERTIFICATE OF DEATH

08215

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X TOWN Delmar</b>		LENGTH OF STAY (In this place) <b>Most of life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN Delmar</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>At home - Route # 1</b>				STREET ADDRESS (If rural give location) <b>Route # 1</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Martha Ellen Price</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>8 - 5 - 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>A.A.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widow</b>	<b>8. DATE OF BIRTH</b> <b>6-6-1873</b>		<b>9. AGE last birthday</b> <b>82 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>29</b>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At home</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Delmar, Wicomico Co., Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Peter W. Henson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Henrietta Parker</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>David J. Hudson, Delmar, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>571.1 IMMEDIATE CAUSE (A)</b> <b>Acute gastro enteritis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>1. Arteriosclerosis, generalized, marked</b>			
				<b>2. Malnutrition, marked.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b>		<b>21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8-5-55, to 8-5-55, that I last saw the deceased alive on 8-5-55, and that death occurred at 7:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>M. D. J. S. S. S.</i>				<b>ADDRESS (Street, city, town, state)</b> <i>Delmar, Md.</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>8-8-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Union Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Aug. 9, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary G. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary A. Stewart</i>		<b>ADDRESS</b> <i>3248 Church St. Salisbury Md.</i>	

**RECEIVED**  
**BUREAU V. S.**  
 AUG 9 1955

1. NAME OF DECEASED William J. Nelson		2. SEX Male		3. AGE 38		4. DATE OF DEATH 8-8-1955		5. PLACE OF DEATH At home - Room 41		6. CAUSE OF DEATH Heart failure	
7. PLACE OF BIRTH Wisconsin		8. PLACE OF DEATH At home		9. DATE OF DEATH 8-8-1955		10. PLACE OF DEATH At home		11. CAUSE OF DEATH Heart failure		12. PLACE OF DEATH At home	
13. NAME OF DECEASED William J. Nelson		14. SEX Male		15. AGE 38		16. DATE OF DEATH 8-8-1955		17. PLACE OF DEATH At home		18. CAUSE OF DEATH Heart failure	
19. NAME OF DECEASED William J. Nelson		20. SEX Male		21. AGE 38		22. DATE OF DEATH 8-8-1955		23. PLACE OF DEATH At home		24. CAUSE OF DEATH Heart failure	

RECEIVED  
 AUG 9 1955  
 BUREAU V. S.

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1 8204

## CERTIFICATE OF DEATH

08216

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>(D. C.)</u>		COUNTY <u>(Res. Prince George's County, Md.)</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
12 TOWN <u>Salisbury</u>		9 months		TOWN <u>Washington 21</u>		16X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				2521 Southern Avenue			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>CATHERINE PEACOCK PURDY</u>				Aug. 13 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	W	Separated	12/3/1899	55 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
--			--		Washington, D. C.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Paul Yates Peacock</u>				<u>Catherine Lanham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		--		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage involving</u>						24 hrs.	
ANTECEDENT CAUSE(S) DUE TO <u>Medulla oblongata</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerosis</u>						2	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>						2	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-2</u> , 19 <u>54</u> , to <u>8-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-12</u> , 19 <u>55</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>8-13-55</u>	
M. D. <u>[Signature]</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 16-55</u>		<u>Cedar Hill</u>		<u>Suitland Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-15-55</u>		<u>Mary Hallaway</u>		<u>William B. Bro.</u>		<u>1661 - 2nd Hope Rd Wash. D.C. 55</u>	

# CERTIFICATE OF DEATH

06516

Reg. Cert. No. 350

1. NAME - SURVIVOR OF DEATH

2. NAME - DEATH

3. NAME - SURVIVOR OF DEATH

4. NAME - SURVIVOR OF DEATH

5. NAME - SURVIVOR OF DEATH

6. NAME - SURVIVOR OF DEATH

7. NAME - SURVIVOR OF DEATH

8. NAME - SURVIVOR OF DEATH

9. NAME - SURVIVOR OF DEATH

10. NAME - SURVIVOR OF DEATH

11. NAME - SURVIVOR OF DEATH

12. NAME - SURVIVOR OF DEATH

13. NAME - SURVIVOR OF DEATH

14. NAME - SURVIVOR OF DEATH

15. NAME - SURVIVOR OF DEATH

16. NAME - SURVIVOR OF DEATH

17. NAME - SURVIVOR OF DEATH

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20. NAME - SURVIVOR OF DEATH

21. NAME - SURVIVOR OF DEATH

22. NAME - SURVIVOR OF DEATH

23. NAME - SURVIVOR OF DEATH

24. NAME - SURVIVOR OF DEATH

25. NAME - SURVIVOR OF DEATH

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27. NAME - SURVIVOR OF DEATH

28. NAME - SURVIVOR OF DEATH

29. NAME - SURVIVOR OF DEATH

30. NAME - SURVIVOR OF DEATH

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33. NAME - SURVIVOR OF DEATH

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51. NAME - SURVIVOR OF DEATH

52. NAME - SURVIVOR OF DEATH

53. NAME - SURVIVOR OF DEATH

54. NAME - SURVIVOR OF DEATH

55. NAME - SURVIVOR OF DEATH

56. NAME - SURVIVOR OF DEATH

57. NAME - SURVIVOR OF DEATH

58. NAME - SURVIVOR OF DEATH

59. NAME - SURVIVOR OF DEATH

60. NAME - SURVIVOR OF DEATH

BUREAU V. S.

AUG 15 1955

RECEIVED

8-15-55

11-15-55

PRODUCTION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8205  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08217 Reg. Dist.

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Wicomico</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>New York City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>D.O.A.</u>		STREET ADDRESS (If rural, give location) <u>69X-3</u> ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Con</u>	(Middle) <u>Lee</u>	(Last) <u>Russell</u>	(Month) <u>8</u> (Day) <u>12</u> (Year) <u>1955</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>Coe</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept 14, 1919</u>
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Religious</u>		9b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	9. AGE last birthday: <u>3/4</u> 35 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. CITIZENSHIP (State or foreign country): <u>D. Carolina</u>		10b. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
11. FATHER'S NAME: <u>Clifford Baxter Sr</u>		12. MOTHER'S MAIDEN NAME: <u>Robena E. Case</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		14. SOCIAL SECURITY No.: <u>?</u>	
15. INFORMANT & ADDRESS: <u>Alfred Russell</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
816X Immediate cause (a)..... DUE TO <u>Amibed chest</u>		<u>Fracture left femur</u>	<u>Sudden</u>
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Fracture left femur</u> stating underlying cause last (c).....			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, place bldg, etc.) OF INJURY <u>Street</u>	21c. (City or town) <u>Salisbury</u>	(County) <u>Wicomico</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8 12 55 A.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto struck by bus</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Earl L. Boyer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8-13-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Aug 18, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mamie AC</u>	LOCATION (City, town, or county) (State) <u>Mamie AC</u>
DATE REC'D BY LOCAL REG. <u>8-15-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Booker McClush</u>	ADDRESS <u>Salisbury MD</u>

BUREAU V. S.

AUG 17 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08218

8206

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>10 Days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula General Hospital</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>HOMER SMITH SHOCKLEY</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>8 17 19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>March 14, 1914</b>		<b>9. AGE last birthday</b> <b>41</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Electrolux Co.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Elijah T. Shockley</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Parker</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-01-9661</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Alice P. Shockley</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>592X</b> IMMEDIATE CAUSE (A) <b>Uremic acidosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic glomerulonephritis</b>						<b>25 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>acute glomerulonephritis</b>						<b>25 years ago +</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>myocardial degeneration</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>June 28, 1955</b> <b>to</b> <b>8/17, 1955</b> <b>, that I last saw the deceased alive on</b> <b>8/17, 1955</b> <b>, and that death occurred at</b> <b>11:30</b> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Larry Matley</b>		<b>M.D.</b> <b>Salisbury, Md.</b>		<b>ADDRESS (Street, city, town, state)</b> <b>Salisbury, Md.</b>		<b>DATE SIGNED</b> <b>8/20/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>8/20/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Aug. 22, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The Hill &amp; Johnson Co. Salisbury, Md.</b> <b>Norman F. Robar</b>			

18818

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# CERTIFICATE OF DEATH

Form 100-1-1

Place of Birth: Maryland

Place of Death: Baltimore

Age: 10 days

Sex: Male

Place of Death: General Hospital

Married: Yes

Married: Yes

Married: Yes

Male

White

Married

Married

Signature

Signature

Signature

Signature

Signature

230-11-1111

Mr. Alice P. Shookley

BUREAU V. 2

AUG 22 1955

RECEIVED

Persons

Persons

Persons

THE BALTIMORE

NOTIFICATION OF DEATH TO NEAREST RELATIVE  
The undersigned, Registrar of the Baltimore Health Department, hereby certifies that the death of the person named above has been duly registered and that the death certificate has been issued and filed in the files of the Department.  
WITNESSED my hand and the seal of the Department this 22nd day of August, 1955.  
REGISTRAR

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8207

## CERTIFICATE OF DEATH

08219

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Virginia</i> COUNTY <i>Accomack</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Salisbury</i>				TOWN <i>Chincoteague</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Hill Sanatorium</i>				STREET ADDRESS (If rural give location) <i>83X-3</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>MARTHA E. SHAWARD</i>				<b>4. DATE OF DEATH</b> (Month) <i>Aug</i> (Day) <i>7</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug 23 1866</i>	9. AGE last birthday <i>88</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charlie A. Green</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT & ADDRESS <i>Mrs Frank E Howard Chincoteague Va</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <i>442</i>				CARDIOVASCULAR renal disease			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 1954</i> , to <i>Aug 6</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Aug 5</i> , 19 <i>55</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Phyllis A. Husley</i>				ADDRESS (Street, City, town, state) <i>Salisbury Md</i>		DATE SIGNED <i>8-9-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug 9 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Saylor Memorial</i>		LOCATION (City, town, or county) (State) <i>Temperanceville Va</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary L. Holloman</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter M. C. Park</i>		ADDRESS <i>Chincoteague Va</i>	
DATE <i>7-9-55</i>							



CERTIFICATE OF DEATH

Form 100-101

LOCAL HEALTH DEPARTMENT OR DISTRICT

STATE OF MARYLAND

1. NAME OF DECEASED	2. SEX	3. AGE	4. RACE
5. DATE OF DEATH	6. PLACE OF DEATH	7. CAUSE OF DEATH	8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN	10. SIGNATURE OF REGISTRAR
11. SIGNATURE OF WITNESSES	12. SIGNATURE OF DECEASED

*Handwritten notes:*  
 430-1-100  
 100-1-100  
 100-1-100

*Handwritten notes:*  
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 100-1-100

BUREAU V. 3

AUG 11 1955

RECEIVED

*Handwritten notes at bottom:*  
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 100-1-100

2001001210



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8208

## CERTIFICATE OF DEATH

08220

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>3 wks</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location) <u>108 Livingston Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>E.</u> (Last) <u>Skiles, Jr.</u>				(Month) <u>Aug.</u> (Day) <u>12</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 8, 1913</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laundry Superv. State Hospital</u>		<u>Mt. Pleasant, Penna.</u>		<u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Harry E. Skiles, Sr.</u>				<u>Cora Hatfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>W.W.II</u>				<u>108 Livingston St</u> <u>Mrs. Reta Skiles Salisbury, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
155X IMMEDIATE CAUSE (A) <u>Adenocarcinoma Common Bile Duct</u>						<u>6 Mos Ago</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>7-29-55</u>		<u>Above</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 24, 1955</u> , to <u>Aug 12, 1955</u> , that I last saw the deceased alive on <u>8-12</u> , 19 <u>55</u> , and that death occurred at <u>2</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John M. Bledom III</u>				<u>Salisbury, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/16/1955</u>		<u>Rose Hill Cemetery</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-15-55</u>		<u>Mary Hollaway</u>		<u>Thomas T. Wallen</u>		<u>Salisbury, Md.</u>	

21010501054

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE BUREAU OF VITAL STATISTICS OF THE STATE OF MARYLAND. THE DEATH OF THIS PERSON HAS BEEN REPORTED TO THE BUREAU OF VITAL STATISTICS OF THE STATE OF MARYLAND BY THE LOCAL HEALTH OFFICIALS OF THE DISTRICT OF COLUMBIA. THE DEATH OF THIS PERSON HAS BEEN REPORTED TO THE BUREAU OF VITAL STATISTICS OF THE STATE OF MARYLAND BY THE LOCAL HEALTH OFFICIALS OF THE DISTRICT OF COLUMBIA.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1955

DATE OF DEATH: AUG 15 1955

1. NAME OF DECEASED: [REDACTED]

2. SEX: [REDACTED]

3. AGE: [REDACTED]

4. RACE: [REDACTED]

5. BIRTH DATE: [REDACTED]

6. BIRTH PLACE: [REDACTED]

7. MARRIAGE DATE: [REDACTED]

8. MARRIAGE PLACE: [REDACTED]

9. OCCUPATION: [REDACTED]

10. CAUSE OF DEATH: [REDACTED]

11. PLACE OF DEATH: [REDACTED]

12. TIME OF DEATH: [REDACTED]

13. SIGNATURE OF DECEASED: [REDACTED]

14. SIGNATURE OF WITNESS: [REDACTED]

15. SIGNATURE OF PHYSICIAN: [REDACTED]

16. SIGNATURE OF CORONER: [REDACTED]

17. SIGNATURE OF JUDGE: [REDACTED]

18. SIGNATURE OF CLERK: [REDACTED]

19. SIGNATURE OF NOTARY: [REDACTED]

20. SIGNATURE OF [REDACTED]: [REDACTED]

21. SIGNATURE OF [REDACTED]: [REDACTED]

22. SIGNATURE OF [REDACTED]: [REDACTED]

23. SIGNATURE OF [REDACTED]: [REDACTED]

24. SIGNATURE OF [REDACTED]: [REDACTED]

25. SIGNATURE OF [REDACTED]: [REDACTED]

26. SIGNATURE OF [REDACTED]: [REDACTED]

27. SIGNATURE OF [REDACTED]: [REDACTED]

28. SIGNATURE OF [REDACTED]: [REDACTED]

29. SIGNATURE OF [REDACTED]: [REDACTED]

30. SIGNATURE OF [REDACTED]: [REDACTED]

31. SIGNATURE OF [REDACTED]: [REDACTED]

32. SIGNATURE OF [REDACTED]: [REDACTED]

33. SIGNATURE OF [REDACTED]: [REDACTED]

34. SIGNATURE OF [REDACTED]: [REDACTED]

35. SIGNATURE OF [REDACTED]: [REDACTED]

36. SIGNATURE OF [REDACTED]: [REDACTED]

37. SIGNATURE OF [REDACTED]: [REDACTED]

38. SIGNATURE OF [REDACTED]: [REDACTED]

39. SIGNATURE OF [REDACTED]: [REDACTED]

40. SIGNATURE OF [REDACTED]: [REDACTED]

41. SIGNATURE OF [REDACTED]: [REDACTED]

42. SIGNATURE OF [REDACTED]: [REDACTED]

43. SIGNATURE OF [REDACTED]: [REDACTED]

44. SIGNATURE OF [REDACTED]: [REDACTED]

45. SIGNATURE OF [REDACTED]: [REDACTED]

46. SIGNATURE OF [REDACTED]: [REDACTED]

47. SIGNATURE OF [REDACTED]: [REDACTED]

48. SIGNATURE OF [REDACTED]: [REDACTED]

49. SIGNATURE OF [REDACTED]: [REDACTED]

50. SIGNATURE OF [REDACTED]: [REDACTED]

51. SIGNATURE OF [REDACTED]: [REDACTED]

52. SIGNATURE OF [REDACTED]: [REDACTED]

53. SIGNATURE OF [REDACTED]: [REDACTED]

54. SIGNATURE OF [REDACTED]: [REDACTED]

55. SIGNATURE OF [REDACTED]: [REDACTED]

56. SIGNATURE OF [REDACTED]: [REDACTED]

57. SIGNATURE OF [REDACTED]: [REDACTED]

58. SIGNATURE OF [REDACTED]: [REDACTED]

59. SIGNATURE OF [REDACTED]: [REDACTED]

60. SIGNATURE OF [REDACTED]: [REDACTED]

61. SIGNATURE OF [REDACTED]: [REDACTED]

62. SIGNATURE OF [REDACTED]: [REDACTED]

63. SIGNATURE OF [REDACTED]: [REDACTED]

64. SIGNATURE OF [REDACTED]: [REDACTED]

65. SIGNATURE OF [REDACTED]: [REDACTED]

66. SIGNATURE OF [REDACTED]: [REDACTED]

67. SIGNATURE OF [REDACTED]: [REDACTED]

68. SIGNATURE OF [REDACTED]: [REDACTED]

69. SIGNATURE OF [REDACTED]: [REDACTED]

70. SIGNATURE OF [REDACTED]: [REDACTED]

71. SIGNATURE OF [REDACTED]: [REDACTED]

72. SIGNATURE OF [REDACTED]: [REDACTED]

73. SIGNATURE OF [REDACTED]: [REDACTED]

74. SIGNATURE OF [REDACTED]: [REDACTED]

75. SIGNATURE OF [REDACTED]: [REDACTED]

76. SIGNATURE OF [REDACTED]: [REDACTED]

77. SIGNATURE OF [REDACTED]: [REDACTED]

78. SIGNATURE OF [REDACTED]: [REDACTED]

79. SIGNATURE OF [REDACTED]: [REDACTED]

80. SIGNATURE OF [REDACTED]: [REDACTED]

81. SIGNATURE OF [REDACTED]: [REDACTED]

82. SIGNATURE OF [REDACTED]: [REDACTED]

83. SIGNATURE OF [REDACTED]: [REDACTED]

84. SIGNATURE OF [REDACTED]: [REDACTED]

85. SIGNATURE OF [REDACTED]: [REDACTED]

86. SIGNATURE OF [REDACTED]: [REDACTED]

87. SIGNATURE OF [REDACTED]: [REDACTED]

88. SIGNATURE OF [REDACTED]: [REDACTED]

89. SIGNATURE OF [REDACTED]: [REDACTED]

90. SIGNATURE OF [REDACTED]: [REDACTED]

91. SIGNATURE OF [REDACTED]: [REDACTED]

92. SIGNATURE OF [REDACTED]: [REDACTED]

93. SIGNATURE OF [REDACTED]: [REDACTED]

94. SIGNATURE OF [REDACTED]: [REDACTED]

95. SIGNATURE OF [REDACTED]: [REDACTED]

96. SIGNATURE OF [REDACTED]: [REDACTED]

97. SIGNATURE OF [REDACTED]: [REDACTED]

98. SIGNATURE OF [REDACTED]: [REDACTED]

99. SIGNATURE OF [REDACTED]: [REDACTED]

100. SIGNATURE OF [REDACTED]: [REDACTED]

BUREAU V. 1

AUG 15 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08221

8209

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>54 days</u>		TOWN <u>Easton</u>		<u>20x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route # 4</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Ida</u> <u>Spencer</u>				<u>August 23</u> <u>1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>F</u>	<u>White</u>	<u>Single</u>	<u>October 22, 1875</u>	<u>79</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Unknown</u>		<u>- -</u>		<u>Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Edward Spencer</u>				<u>Mary Satchell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>unk.</u>		<u>- -</u>		<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>332X</b> IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>June 30, 1955</u> , to <u>Aug. 23, 1955</u> , that I last saw the deceased alive on <u>Aug. 23, 1955</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<u>L.V. Maldve</u>		<u>L.V. Maldve, M.D. Deer's Head State Hospital Salisbury, Maryland</u>		<u>8/23/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>BURIAL</u>		<u>8-25-55</u>		<u>SPRING HILL CEMETERY</u>		<u>EASTON, MARYLAND</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Aug. 26, 1955</u>		<u>Mary H. Hollaway</u>		<u>W. Brampton Canoll</u>		<u>Easton, Md.</u>	

08321

WASHINGTON STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

# DEATH CERTIFICATE

Form No. 1

State of Washington, County of \_\_\_\_\_

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Registration		Place of Registration		Signature of Registrar	

BUREAU V. 2

JUG 26 1955

RECEIVED

TO ALL WHOM THESE PRESENTS SHALL COME, I, the undersigned, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Department of Health of the State of Washington.

WITNESSED my hand and the seal of said Department at the City of Seattle, this 26th day of June, 1955.

\_\_\_\_\_  
Registrar

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08222

8224

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Pennsylvania</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Seaside</u>		<u>5 Wks</u>		TOWN <u>Philadelphia</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>3438 Tilden St.</u>				<u>3438 Tilden St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
<u>Walter L. Stevenson</u>				<u>8-16-55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
				<u>Married</u>		<u>10-17-1897</u>	
				<u>57</u> yrs.		<u>7</u> Months <u>27</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Phil. Tilden Co. Seaside, Pa.</u>				<u>Seaside, Pa.</u>		<u>Pa.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James B. Stevenson</u>				<u>Thie Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Wm. W. Stevenson, Phil., Pa.</u>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>1 Day</u>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Myocardial Infarction</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 16<sup>th</sup></u> , 19 <u>55</u> , to <u>Aug 16<sup>th</sup></u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 16<sup>th</sup></u> , 19 <u>55</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ch. E. Emswiler</u>				M.D.		DATE SIGNED <u>Aug 16<sup>th</sup></u>	
ADDRESS (Street, city, town, state)				ADDRESS (Street, city, town, state)			
<u>Seaside, Pa.</u>				<u>Seaside, Pa.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>8/20/55</u>		<u>Mount Peace Cem.</u>		<u>Philadelphia, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug. 18, 1955</u>		<u>Mary H. Holloway</u>		<u>Cornelia S. Mersick</u>		<u>Seaside, Pa.</u>	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8225  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08223  
Reg. Dist.  
No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Pennsylvania</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
<input checked="" type="checkbox"/> TOWN <u>Salisbury</u>				TOWN <u>Aliquippa</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R F D # 13 near old Delmar Rd.</u>				STREET ADDRESS (If rural, give location) <u>209 Kiehl St.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Frank</u>		(Middle) <u>Stewart</u>		(Last)	
				4. DATE OF DEATH		(Month) (Day) (Year) <u>8-11-55</u> <u>19</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify <u>unknown</u> )		8. DATE OF BIRTH: (Est.) <u>40</u>		9. AGE last birthday: <u>unknown</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Ben Ben Haag</u>	

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>812X</u> Immediate cause (a) <u>Fractured cervical spine and</u> DUE TO Antecedent cause(s) (b) <u>Bilateral fractured tibia and fibula.</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>RFD # 13</u> )		21c. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-11-55 11:45 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Struck by auto while crossing road.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Hays</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>8-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Anatomical Bldg. Baltimore Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>8-17-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Boaker W. Wright</u>		ADDRESS <u>Salisbury Md.</u>	

BUREAU V. 1

AUG 19 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8210

08224

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury-Md.</u>		LENGTH OF STAY (in this place) <u>3 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>83X-3</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Constance SNEAD Taylor</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Aug 14 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>June 9</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION - ONANCOCK VA</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas W. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Susan Lankford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>FRANCIS TAYLOR</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
442X IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-25, 1955</u> , to <u>8-14, 1955</u> , that I last saw the deceased alive on <u>8-13, 1955</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Fluora Lush</u>		M.D. <u>Salisbury Md</u>		ADDRESS (Street, city, town, state) <u>5-15255</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>AUG. 16-55</u>		NAME OF CEMETERY OR CREMATORY <u>ONANCOCK</u>		LOCATION (City, town, or county) (State) <u>ONANCOCK VA.</u>	
24. REC'D BY REGISTRAR <u>Aug. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>For - 16llam</u>		ADDRESS <u>5-1-11 Onanocks Va</u>	

65234

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

# CERTIFICATE OF DEATH

65234

Reg. No. 100

1. NAME OF DECEASED

2. SEX

3. RACE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESS

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF REGISTRAR

BUREAU V. 3

AUG 23 1955

RECEIVED

8211

## CERTIFICATE OF DEATH

Reg. Dist. No. 032

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		TOWN <u>Snow Hill</u>	<u>23X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location)	<u>14 Cavington Street</u>
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
<u>William H. Truitt</u>	DEATH: <u>August 25</u> 19 <u>55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 13, 1883</u>
9. AGE last birthday <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Leven Truitt</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Rounds</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FOREST (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-24-2702</u>	
17. INFORMANT & ADDRESS: <u>Lola Truitt, Snow Hill, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
491X IMMEDIATE CAUSE (A) <u>Uremia</u>			
ANTECEDENT CAUSE (B) <u>Small bowel hemorrhage</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>aspiration pneumonia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Syphilitic Aortitis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. C. Mitchell</u>		DATE SIGNED <u>8/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke's Episcopal Church</u>	
DATE REG'D BY LOCAL REGISTRAR <u>8-26-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
FUNERAL DIRECTOR <u>Clayton</u>		ADDRESS <u>Snow Hill, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 29 1955

RECEIVED



## 8212 CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

COUNTY Wicomico MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS PENINSULA GENERAL Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY WorcesterCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NEWARK 23X-2

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

ELwoodTull

## 4. DATE (Month) (Day) (Year)

OF

DEATH:

August 28 1955

## 5. SEX:

## 6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MALEwhiteWIDOWEDJuly 29, 189560 yrs.8 Months 29 Days0 Hours 0 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY:

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

## IMMEDIATE CAUSE

(A)

DUE TO

## ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

## 21E. INJURY OCCURRED

While ☐ Not while ☐at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9, 1955 to 8-28, 1955 that I last saw the deceasedalive on 8-28, 1955 and that death occurred at 11:40 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8-30-55Mary W. HollowayClay AdamsSalisbury, Md

MARGIN RESERVED FOR BINDING

I

BUREAU V. S.

SEP 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8225  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08227  
Reg. Dist.  
No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN	LENGTH OF STAY (in this place) <i>13 years</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Nanticoke</i>	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Nanticoke</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Samuel</i>	(Middle) <i>Harold</i>	(Last) <i>Turner Jr.</i>	(Month) <i>8</i> (Day) <i>2</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>April 26, 1942</i>
9. AGE last birthday: <i>13</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>		13. FATHER'S NAME: <i>Samuel H. Turner Sr.</i>	
14. MOTHER'S MAIDEN NAME: <i>Marie Mutter</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>929.8 Immediate cause (a) <i>Drowning</i> DUE TO</p> <p>Antecedent cause(s) (b) <i>giving rise to the above cause</i> DUE TO</p> <p>stating underlying cause last (c)</p>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Nanticoke Wicomico Md.</i>	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>8 2 55 20 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Drowned while swimming</i>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *Earl L. Boyer*

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED *8-3-55*  
DEPUTY MEDICAL EXAMINER ☒  
M. D. ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>	DATE THEREOF: <i>8-7-55</i>	NAME OF CEMETERY OR CREMATORY: <i>Nanticoke Cemetery</i>	LOCATION (City, town, or county) (State): <i>Nanticoke Md.</i>
DATE REC'D BY LOCAL REG. <i>8-5-55</i>	REGISTRAR'S SIGNATURE: <i>Mary W. Holloway</i>	24. FUNERAL DIRECTOR: <i>Levin R. Wilson</i>	ADDRESS: <i>Princeton Anne, Md.</i>

06383

06383

RECEIVED  
AUG 8 1955  
BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08228

8213

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Worcester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <b>Salisbury</b>		<b>Few days</b>		near <b>Berlin</b>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <b>Peninsula General Hospital</b>				<b>Migrant Worker</b> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Georgia</b> (Middle) <b>Mae</b> (Last) <b>Williams</b>				(Month) <b>8</b> (Day) <b>29</b> (Year) <b>19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>A.A.</b>	<b>Married</b>	<b>8-26-1930</b>	<b>25 yrs.</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Migrant Worker</b>		<b>Farm</b>		<b>Augusta, Richmond Co., Ga.</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Cleciest A. Biven</b>				<b>Mary L. Coleman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>Unk</b> (If Yes, give war or dates of service)		<b>Unk</b>		<b>Mrs. Sarah Johnson, 7th. Ave. Augusta, Ga.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
590X IMMEDIATE CAUSE (A)				<b>acute glomerulonephritis</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<b>1 month</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>8-10</b> , 19 <b>55</b> , to <b>8-29</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8-29</b> , 19 <b>55</b> , and that death occurred at <b>11:00</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Charles Burksley</b>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<b>Salisbury, Md</b>		<b>9-1-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>9-4-55</b>		<b>Givens Cemetery</b>		<b>Burke's Co. Ga.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Sept. 6, 1955</b>		<b>Mary H. Holloway</b>		<b>Mary A. Stewart</b>		<b>324 E. Church Street Salisbury, Maryland</b>	

RECEIVED

SEP 6 1955

BUREAU V. E.

Bureau of Census		Bureau of Census	
U.S. Department of Health, Education and Welfare		U.S. Department of Health, Education and Welfare	
Washington, D.C. 20540		Washington, D.C. 20540	
Form 100-1 (Rev. 1-55)		Form 100-1 (Rev. 1-55)	
1. Name (Last, First, Middle)		1. Name (Last, First, Middle)	
2. Date of Birth (Month, Day, Year)		2. Date of Birth (Month, Day, Year)	
3. Sex		3. Sex	
4. Race		4. Race	
5. Marital Status		5. Marital Status	
6. Education		6. Education	
7. Occupation		7. Occupation	
8. Place of Birth		8. Place of Birth	
9. Date of Entry into Country		9. Date of Entry into Country	
10. Date of Death		10. Date of Death	
11. Cause of Death		11. Cause of Death	
12. Place of Death		12. Place of Death	
13. Signature of Informant		13. Signature of Informant	
14. Informant's Address		14. Informant's Address	
15. Informant's Telephone		15. Informant's Telephone	
16. Informant's Relationship to Deceased		16. Informant's Relationship to Deceased	
17. Informant's Signature		17. Informant's Signature	
18. Informant's Address		18. Informant's Address	
19. Informant's Telephone		19. Informant's Telephone	
20. Informant's Relationship to Deceased		20. Informant's Relationship to Deceased	
21. Informant's Signature		21. Informant's Signature	
22. Informant's Address		22. Informant's Address	
23. Informant's Telephone		23. Informant's Telephone	
24. Informant's Relationship to Deceased		24. Informant's Relationship to Deceased	
25. Informant's Signature		25. Informant's Signature	
26. Informant's Address		26. Informant's Address	
27. Informant's Telephone		27. Informant's Telephone	
28. Informant's Relationship to Deceased		28. Informant's Relationship to Deceased	
29. Informant's Signature		29. Informant's Signature	
30. Informant's Address		30. Informant's Address	
31. Informant's Telephone		31. Informant's Telephone	
32. Informant's Relationship to Deceased		32. Informant's Relationship to Deceased	
33. Informant's Signature		33. Informant's Signature	
34. Informant's Address		34. Informant's Address	
35. Informant's Telephone		35. Informant's Telephone	
36. Informant's Relationship to Deceased		36. Informant's Relationship to Deceased	
37. Informant's Signature		37. Informant's Signature	
38. Informant's Address		38. Informant's Address	
39. Informant's Telephone		39. Informant's Telephone	
40. Informant's Relationship to Deceased		40. Informant's Relationship to Deceased	
41. Informant's Signature		41. Informant's Signature	
42. Informant's Address		42. Informant's Address	
43. Informant's Telephone		43. Informant's Telephone	
44. Informant's Relationship to Deceased		44. Informant's Relationship to Deceased	
45. Informant's Signature		45. Informant's Signature	
46. Informant's Address		46. Informant's Address	
47. Informant's Telephone		47. Informant's Telephone	
48. Informant's Relationship to Deceased		48. Informant's Relationship to Deceased	
49. Informant's Signature		49. Informant's Signature	
50. Informant's Address		50. Informant's Address	
51. Informant's Telephone		51. Informant's Telephone	
52. Informant's Relationship to Deceased		52. Informant's Relationship to Deceased	
53. Informant's Signature		53. Informant's Signature	
54. Informant's Address		54. Informant's Address	
55. Informant's Telephone		55. Informant's Telephone	
56. Informant's Relationship to Deceased		56. Informant's Relationship to Deceased	
57. Informant's Signature		57. Informant's Signature	
58. Informant's Address		58. Informant's Address	
59. Informant's Telephone		59. Informant's Telephone	
60. Informant's Relationship to Deceased		60. Informant's Relationship to Deceased	
61. Informant's Signature		61. Informant's Signature	
62. Informant's Address		62. Informant's Address	
63. Informant's Telephone		63. Informant's Telephone	
64. Informant's Relationship to Deceased		64. Informant's Relationship to Deceased	
65. Informant's Signature		65. Informant's Signature	
66. Informant's Address		66. Informant's Address	
67. Informant's Telephone		67. Informant's Telephone	
68. Informant's Relationship to Deceased		68. Informant's Relationship to Deceased	
69. Informant's Signature		69. Informant's Signature	
70. Informant's Address		70. Informant's Address	
71. Informant's Telephone		71. Informant's Telephone	
72. Informant's Relationship to Deceased		72. Informant's Relationship to Deceased	
73. Informant's Signature		73. Informant's Signature	
74. Informant's Address		74. Informant's Address	
75. Informant's Telephone		75. Informant's Telephone	
76. Informant's Relationship to Deceased		76. Informant's Relationship to Deceased	
77. Informant's Signature		77. Informant's Signature	
78. Informant's Address		78. Informant's Address	
79. Informant's Telephone		79. Informant's Telephone	
80. Informant's Relationship to Deceased		80. Informant's Relationship to Deceased	
81. Informant's Signature		81. Informant's Signature	
82. Informant's Address		82. Informant's Address	
83. Informant's Telephone		83. Informant's Telephone	
84. Informant's Relationship to Deceased		84. Informant's Relationship to Deceased	
85. Informant's Signature		85. Informant's Signature	
86. Informant's Address		86. Informant's Address	
87. Informant's Telephone		87. Informant's Telephone	
88. Informant's Relationship to Deceased		88. Informant's Relationship to Deceased	
89. Informant's Signature		89. Informant's Signature	
90. Informant's Address		90. Informant's Address	
91. Informant's Telephone		91. Informant's Telephone	
92. Informant's Relationship to Deceased		92. Informant's Relationship to Deceased	
93. Informant's Signature		93. Informant's Signature	
94. Informant's Address		94. Informant's Address	
95. Informant's Telephone		95. Informant's Telephone	
96. Informant's Relationship to Deceased		96. Informant's Relationship to Deceased	
97. Informant's Signature		97. Informant's Signature	
98. Informant's Address		98. Informant's Address	
99. Informant's Telephone		99. Informant's Telephone	
100. Informant's Relationship to Deceased		100. Informant's Relationship to Deceased	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

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